# DEPARTMENT OF HEALTH AND HUMAN SERVICES
## CENTERS FOR DISEASE CONTROL AND PREVENTION
## HEALTH RESOURCES AND SERVICES ADMINISTRATION

# CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment
# May 19-20, 2009
# Atlanta, Georgia

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## Record of the Proceedings

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# TABLE OF CONTENTS

# ATTACHMENT 1

## List of Participants

**CHAC Members**

Dr. Edward Hook III, Co-Chair
Dr. Donna Sweet, Co-Chair
Dr. Bruce Agins
Dr. William Cunningham
Dr. Carlos del Rio
Rev. Debra Hickman
Ms. Antigone Hodgins
Mr. Ernest Hopkins
Ms. Maria Lago
Dr. Jeanne Marrazzao
Dr. Kenneth Mayer
Dr. Andrè Rawls
Ms. Lisa Tiger

**CHAC *Ex-Officio* Representatives**

Dr. William Grace
(National Institutes of Health)
Dr. John Redd (Indian Health Service)

**Designated Federal Officials**

Dr. Kevin Fenton
NCHHSTP Director, CDC
Dr. Deborah Parham Hopson
HAB Director, HRSA

**Federal Agency Representatives**

Dr. Ronald Ballard
Mr. Christopher Bates
Dr. Bernard Branson
Ms. Romonda McKinney Bumpus
Dr. Chris Cagle
Mr. Michael Craig
Mr. Jeffrey Crowley
Dr. John Douglas, Jr.
Ms. Teresa Durden
Ms. Shelley Gordon
Dr. Kathleen McDavid Harrison
Dr. Irene Hall
Dr. James Heffelfinger
Ms. Amy Pulver
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Ms. Sarah Resavy
Mr. Randall Russell
Ms. Margie Scott-Cseh
Ms. Jenny Sewell
Dr. John Su
Dr. John Ward
Dr. Howell Wechsler
Dr. Hillard Weinstock
Dr. Samantha Williams
Dr. Richard Wolitski
Ms. Jo Valentine

**Guest Presenters and Members of the Public**

Ms. Candice Abate (Hepatitis Foundation)
Mr. Jeremy Allen (Vertex Pharmaceuticals)
Ms. Lynn Barclay
American Social Health Association)
Ms. Kelly Beckett (American Liver Foundation)
Ms. Joan Block (Hepatitis B Foundation)
Ms. K. Claires (OTI)
Ms. Laura Donnelly (Southeast AIDS Education and Training Center)
Ms. Raissa Downs (Vertex Pharmaceuticals)
Ms. Debra Fraser-Howze (OraSure)
Ms. Camilla Graham (Vertex Pharmaceuticals)
Ms. Felicia Guest (Southeast AIDS Education and Training Center)
Ms. Laura Hanen (National Alliance of State and Territorial AIDS Directors)
Mr. Ronald Johnson (AIDS Action Council)
Dr. Peter Leone
(National Coalition of STD Directors)
Ms. Mindy Middleton
(AIDS Healthcare Foundation)
Ms. Suzanne Miller
(National Coalition of STD Directors)
Mr. Michael Ninburg
(Hepatitis Education Project)
Ms. Emily Oster (Vertex Pharmaceuticals)
Mr. Amit Sachdev (Vertex Pharmaceuticals)
Mr. Carl Schmid (The AIDS Institute)
Mr. Dennis Simon (Hepatitis C Association)
Dr. Anne Spaulding (Emory University)
Mr. Chris Taylor (National Alliance of State and Territorial AIDS Directors)
Mr. Todd Ungard (Vertex Pharmaceuticals)

# ATTACHMENT 2

## Acronyms Used in These Meeting Minutes

| | | |
|---|---|---|
| AA | — | African American |
| AAC | — | AIDS Action Council |
| ADAP | — | AIDS Drug Assistance Program |
| AETCs | — | AIDS Education and Training Centers |
| AHITS | — | Assessment of HIV Testing in Clinical Settings |
| AHRQ | — | Agency for Healthcare Research and Quality |
| ARRA | — | American Recovery and Reinvestment Act |
| ATSDR | — | Agency for Toxic Substances and Disease Registry |
| BHPr | — | Bureau of Health Professions |
| CBOs | — | Community-Based Organizations |
| CDC | — | Centers for Disease Control and Prevention |
| CER | — | Comparative Effectiveness Research |
| CHAC | — | CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment |
| CHCs | — | Community Health Centers |
| CheCS | — | Chronic Hepatitis Cohort Study |
| CMS | — | Centers for Medicare and Medicaid Services |
| DASH | — | Division of Adolescent and School Health |
| DHAP | — | Division of HIV/AIDS Prevention |
| DIS | — | Disease Intervention Specialist |
| DSTDP | — | Division of STD Prevention |
| DVH | — | Division of Viral Hepatitis |
| EBAPs | — | Evidence-Based Action Plans |
| EDs | — | Emergency Departments |
| eHARS | — | Electronic HIV/AIDS Reporting System |
| EIA | — | Enzyme Immunoassay |
| EnhanceLink | — | Enhancing Linkages to HIV Primary Care in Jail Settings |
| FAPP | — | Federal AIDS Policy Partnership |
| FCC | — | Federal Coordinating Council |
| FDA | — | Food and Drug Administration |
| GAO | — | U.S. Government Accountability Office |
| GYT | — | Get Yourself Tested! |
| HAB | — | HIV/AIDS Bureau |
| HBV | — | Hepatitis B Virus |
| HCV | — | Hepatitis C Virus |
| HHS | — | Department of Health and Human Services |
| HIT | — | Health Information Technology |
| HMA | — | High Morbidity Area |
| HRSA | — | Health Resources and Services Administration |
| IDU | — | Injection Drug Use |
| IOM | — | Institute of Medicine |
| *MMWR* | — | *Morbidity and Mortality Weekly Report* |
| MSM | — | Men Who Have Sex With Men |
| NAAT | — | Nucleic Acid Amplification Testing |
| NACCHO | — | National Association of County and City Health Officials |
| NASTAD | — | National Alliance of State and Territorial AIDS Directors |

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|---|---|---|
| NCHHSTP | — | National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention |
| NCSD | — | National Coalition of STD Directors |
| NHBS | — | National HIV Behavioral Surveillance System |
| NIH | — | National Institutes of Health |
| NIMH | — | National Institute of Mental Health |
| OIG | — | Office of Inspector General |
| P&S | — | Primary and Secondary Syphilis |
| PACHA | — | President's Advisory Council on HIV/AIDS |
| PCPs | — | Primary Care Providers |
| PCSI | — | Program Collaboration and Service Integration |
| PEPFAR | — | President's Emergency Plan for AIDS Relief |
| PLWH | — | Persons Living with HIV |
| POC | — | Point-of-Care |
| SAMHSA | — | Substance Abuse and Mental Health Service Administration |
| SBAP | — | Supplemental Behavioral Assessment Project |
| SDH | — | Social Determinants of Health |
| SEE | — | Syphilis Elimination Effort |
| SHARED | — | State HIV/AIDS Resources and Educational Discussions |
| SSuN | — | STD Surveillance Network |
| TGAs | — | Transitional Grant Areas |
| VA | — | Department of Veterans Affairs |
| WHO | — | World Health Organization |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES
## CENTERS FOR DISEASE CONTROL AND PREVENTION
## HEALTH RESOURCES AND SERVICES ADMINISTRATION

## CDC/HRSA ADVISORY COMMITTEE ON HIV AND STD PREVENTION AND TREATMENT
## May 19-20, 2009
## Atlanta, Georgia

# Minutes of the Meeting

The Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA) convened a meeting of the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC). The proceedings were held at the J.W. Marriott Buckhead Hotel in Atlanta, Georgia on May 19-20, 2009.

### Opening Session

Dr. Edward Hook III, co-Chair of CHAC, called the meeting to order at 8:30 a.m. on May 19, 2009. He welcomed the attendees to the proceedings and particularly recognized the new CHAC members: Mr. Ernest Hopkins; Drs. Carlos del Rio, Jeanne Marrazzo and Kenneth Mayer; and Dr. Jose Esparza *in absentia*. Dr. Hook noted that abbreviated biographical sketches of the four new CHAC members were distributed in the meeting packets. The list of participants is appended to the minutes as Attachment 1.

Dr. Kevin Fenton, Director of the CDC National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) and the CHAC Designated Federal Official for CDC, reminded the participants that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record. He advised CHAC members to be mindful of potential conflicts of interest identified by the CDC or HRSA Committee Management Office and to recuse themselves from participating in discussions or voting on issues in which they have a real or perceived conflict of interest.

## NCHHSTP Director's Report

Dr. Fenton covered the following areas in his update. At the HHS and CDC levels, Congress recently confirmed three nominees for HHS leadership positions. Ms. Kathleen Sebeluis was confirmed as the new HHS Secretary and visited staff of CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) on May 5, 2009. Mr. William Corr was confirmed as the new HHS Deputy Director and Dr. Yvette Roubideaux was confirmed as the new Director of the Indian Health Service.

Dr. Thomas Frieden was appointed as the new CDC Director and will begin serving in this position in early June 2009. Dr. Frieden is the Commissioner of the New York City Department of Health and Mental Hygiene at this time and was employed by CDC for 12 years. He began his career at CDC as an Epidemic Intelligence Service Officer in 1990 and then led CDC's TB control program in India for five years. To ensure a seamless transition to the new leadership, Dr. Richard Bessor, acting Director of CDC, formed a team to assess CDC's organizational changes, provide input on the impact of these changes, and propose options for the incoming permanent director to consider.

The new Administration invested ~$137 billion in HHS's public health programs with American Recovery and Reinvestment Act (ARRA) funding. HHS obligated ~$29 billion of its ARRA funds as of April 17, 2009 and is continuing to develop and execute expenditure plans for the remaining ARRA dollars. Disbursements of ARRA dollars to HHS will include $300 million in direct funding to CDC for immunization of underinsured persons under the 317 Program; $650 million to HHS for community-based prevention and wellness strategies for chronic diseases primarily; and $50 million to HHS for healthcare-associated infections.

HHS will play a key role in four major ARRA policy initiatives. For the "health reform" policy initiative, President Obama made a commitment to collaborate with Congress in passing a comprehensive health reform bill in 2009. HHS assisted in coordinating the "White House Forum on Health Reform" in March 2009 and convening five regional health forums across the country in March and April 2009.

For the "health information technology" (HIT) policy initiative, HHS will help to prioritize advancing the development of a nationwide interoperable HIT infrastructure and accelerating the adoption and implementation of HIT. Assurance of the privacy and security of patient information will be a critical component of the HIT policy initiative.

For the "comparative effectiveness research" (CER) policy initiative, $400 million was allocated to the HHS Office of the Secretary; $400 million was allocated to the National Institutes of Health (NIH); and $300 was allocated to the Agency for Healthcare Research and Quality (AHRQ). The CER policy initiative was designed to provide information on the relative strengths and weaknesses of different medical interventions. HHS must obligate all CER funding by the end of FY2009.

For the "stem cell research" policy initiative, President Obama signed an Executive Order on March 9, 2009 to lift the ban on federal funding for promising human embryonic stem cell research. The Executive Order directed NIH to draft guidelines on conducting stem cell research in a scientifically worthy, responsible and ethical manner.

CDC has been heavily engaged in responding to the H1N1 influenza outbreak over the past six weeks. The World Health Organization (WHO) announced that 33 countries had officially reported 5,728 H1N1 cases as of May 13, 2009, but travel restrictions related to the outbreak were not recommended. CDC established two key goals to respond to the outbreak: (1) reduce the spread and severity of illness and (2) provide information to help healthcare providers, public health officials and the public address challenges posed by this threat. Of 170 NCHHSTP personnel who volunteered to assist the CDC Emergency Operations Center with the H1N1 response, >70 were deployed to headquarters or field assignments.

CDC collaborated with partners to publish recommendations on protective behaviors for persons living with HIV (PLWH) in the context of the novel H1N1 influenza virus. The guidance document outlined recommendations in three major categories: (1) symptom recognition and treatment; (2) self-protective strategies, particularly adherence to currently prescribed HIV medication regimens; and (3) chemoprophylaxis for HIV-positive close contacts of persons with H1N1 infection. The guidance document also noted that PLWH do not appear to be at elevated risk of influenza infection, but might be susceptible to greater complications if infected. CDC posted the guidance document on its web site.

CDC launched the new "ACT Against AIDS Campaign" in April 2009 in partnership with the White House and HHS to link existing and upcoming campaigns and harmonize efforts to mobilize community leaders under a single campaign brand. The press conference at the White House received widespread media coverage. The campaign will be delivered over multiple phases and targeted to diverse audiences over a five-year period. The target audiences include the general public, men who have sex with men (MSM) of all races, African American (AA) women, the general AA population with a primary focus on young persons, physicians, other healthcare providers and patients.

The kick-off phase of the ACT Against AIDS Campaign will focus on a key theme: "Every 9½ minutes, someone in the United States is affected with HIV." The kick-off phase will be targeted to at-risk populations, the general public and stakeholders to raise awareness of and combat complacency toward the domestic HIV/AIDS epidemic as well as to increase information seeking behaviors. Online banner and transit advertisements, viral videos, airport dioramas, radio public service announcements and a campaign web site in both English and Spanish will be used to widely publicize the kick-off phase.

To harness the power of the media, CDC is partnering with the Kaiser Family Foundation to establish a coalition of entertainment, print, online and other media organizations. Partnerships will be established with media organizations to develop campaigns that would complement the ACT Against AIDS campaign. To harness the power of partnerships, the ACT Against AIDS

Leadership Initiative was formed with 14 diverse organizations that have an extensive reach into the AA community.

The development of three campaign phases is underway. The "MSM HIV Testing" phase will aim to achieve behavior change objectives for AA MSM. This phase will be pilot tested online and launched in the spring of 2009. The "Take Charge. Take the Test" phase will aim to achieve behavior change objectives for AA women. The pilot of this phase was extremely successful and will be expanded nationally beginning in June 2009. The "I Know" phase will aim to achieve education and health literacy objectives for the general population of AA young persons. Formative research and planning were initiated and this phase will be launched in June 2009.

At the NCHHSTP level, deliberations are underway to determine the final CDC and ATSDR budgets based on the recent release of the FY2010 President's budget to Congress. NCHHSTP's proposed $1 billion budget includes allocations of ~$745 million for the domestic HIV/AIDS program, ~$153 million for the STD program, and ~$18.4 million for the viral hepatitis program. This funding reflects an increase of ~$54 million above the FY2009 level for pay increases and non-pay increases as well as a $53 million increase for the domestic HIVAIDS program to focus on high-risk populations.

NCHHSTP convened the "Social Determinants of Health" (SDH) Consultation in December 2008 with a diverse group of stakeholders to identify short- and long-term priorities for addressing SDH in four key public health activity areas: public health policy; data systems (surveillance and epidemiology); prevention research and evaluation; and agency partnerships and capacity building for prevention. The participants were divided into breakout groups to provide CDC with guidance on each of the four public health activity areas.

The Public Heath Policy Group advised NCHHSTP to provide leadership throughout CDC and align its efforts with those of HHS and WHO. The group also encouraged NCHHSTP to convene a national agenda setting meeting, partner with other federal agencies, and collaborate with new and established public and private partners.

The Data Systems Group advised NCHHSTP to identify key data elements and measurements; create relevant SDH metrics to be monitored by subject matter experts; incorporate SDH into NCHHSTP's data collection systems; and share, link and integrate data to facilitate data analyses and provide a strong evidence base for SDH.

The Prevention Research and Evaluation Group advised NCHHSTP to reframe traditional individual-based strategies as family-, community-, system-, partnership- and organization-based strategies. For example, NCHHSTP could integrate a holistic and interdisciplinary approach to conducting research and advance toward participatory research in which communities would be engaged from the conceptualization through the final stages.

The Agency Partnerships and Capacity Building Group advised NCHHSTP to enhance partnerships with both traditional and non-traditional sources; include SDH language in funding

opportunity announcements that would require grantees to collaborate with and reach out to partners at state and local levels; and launch a nationwide social marketing campaign to strengthen CDC's relationship with at-risk populations and engage a broader group of partners.

Dr. Fenton asked CHAC to identify NCHHSTP's top three priorities for SDH in the upcoming year based on recommendations proposed by the external consultants, provide a rationale for prioritizing the top three recommendations, and offer additional advice for NCHHSTP to address SDH. The draft SDH report was distributed to CHAC to assist in providing input to NCHHSTP.

NCHHSTP convened several other important consultations following the last CHAC meeting in November 2008: the "HIV Serosorting Consultation" in December 2008; "Corrections and Public Health Consultation: Expanding the Reach of Prevention" in March 2009; "New Community-Based Organization Consultation" in January 2009; and "STD Treatment Guidelines Update" in April 2009.

Recent changes in NCHHSTP leadership include the appointments of Dr. Kathleen McDavid Harrison as the new Associate Director for Health Disparities; Mr. Gustavo Aquino as the Associate Director for Program Integration; and Dr. Jonathan Mermin as the Director of the Division of HIV/AIDS Prevention (DHAP) who will assume this position in July 2009.

At the division level, the Division of STD Prevention (DSTDP) implemented a number of activities to promote "STD Awareness Month" in April 2009. A web site was created and HIV/ STD testing resources were distributed nationwide. The "National Collegiate Contest" was sponsored for students to develop STD awareness campaigns using new media and innovative approaches to reach young adults 18-25 years of age on college campuses and in surrounding communities.

DSTDP launched the national "Get Yourself Tested!" (GYT) campaign in collaboration with MTV, the Kaiser Family Foundation, Planned Parenthood Federation of America and other partners to inform young persons about STDs and promote testing and treatment. The GYT campaign is part of the "It's Your (Sex) Life" public information partnership to help young persons make responsible decisions about their sexual health. On-air, online and mobile channels will be used in the GYT campaign to generate dialogue and help remove stigma around STDs and testing. Celebrity spokespersons, sweepstakes and links to nearby STD testing centers also will encourage young persons to learn more.

DSTDP developed several new STD prevention materials. The STD "The Facts" Brochure is a series of ten award-winning brochures that were developed in plain language for the general public, but is also available to health departments and other partners. The *Guide to Taking a Sexual Health History* is a practical resource for healthcare providers that can be widely shared with providers in communities. STD fact sheets are available on the CDC web site to be downloaded.

DHAP held an external peer review in April 2009 with >70 external particiapnts. The purpose of the peer review was for DHAP to obtain input and guidance on its scientific and programmatic

priorities and direction; provide a basis for CDC's HIV Prevention Strategic Plan; and offer a platform for the development of a National HIV Prevention Plan. The reviewers met in five separate panels and provided preliminary recommenations to CDC.

Overall, the reviewers were impressed with the organization of the peer review and the numerous contributions of DHAP staff and contractors. The reviewers offered constructive feedback and recommendations for future changes. The panel co-chairs are now preparing a draft report and expects to submit the document to the Coordinating Center for Infectious Diseases Board of Scientific Counselors during the November 2009 meeting.

The Division of Adolescent and School Health (DASH) made tremendous progress in developing and releasing new adolescent and school health products. DASH posted a new sexual health chapter of the Health Education Curriculum Analysis Tool on the CDC web site with three new fact sheets on HIV testing in adolescents; HIV-related risk behaviors in AA youth; and HIV in young MSM.

DASH recently released strategies for increasing protective factors among youth through school connectedness. DASH will convene an expert panel in late 2009 to obtain outside expertise in drafting new guidelines for HIV prevention in schools. DASH will integrate sexual health into CDC's updated version of the School Health Index Assessment Tool in early 2010.

Dr. Fenton provided additional details on CDC's ongoing HIV/STD prevention activities in response to CHAC's specific questions and comments. CDC hopes opportunities will be available to use ARRA funding to focus on prevention and public health in general in the health reform policy initiative. This funding would provide an opportunity for federal agencies to advance toward an SDH agenda by developing and implementing structural interventions. NCHHSTP has been proactive in attempting to leverage ARRA funding, but the legislation explicitly states that prevention dollars can only be used for hypertension, diabetes and other "traditional" chronic diseases.

NCHHSTP's strong case on the need to define HIV and hepatitis C virus (HCV) as chronic diseases in ARRA was not supported at either the HHS or CDC level. Based on this outcome, NCHHSTP acknowledged the critical need to expand its constituency base for prevention and established a workgroup to more broadly focus on sexual health. NCHHSTP will present recommendations from the workgroup over time to engage CHAC in efforts to reframe infectious diseases as chronic diseases and strengthen relationships with chronic disease partners.

NCHHSTP recognizes the tremendous erosion in the STD prevention infrastructure and the severe threat to prevention activities due to a weaker workforce. NCHHSTP will continue to submit budget initiatives to HHS and take advantage of other opportunities to leverage additional resources for prevention activities. NCHHSTP also will continue to focus on its top priority of replenishing and building the capacity the public health workforce, particularly for STD and TB prevention.

Dr. Wolitski, acting Director of DHAP, also made remarks in response to CHAC's questions and comments. The proposed increase in the President's FY2010 budget for CDC's prevention activities includes the following allocations: $27 million for further expansion of HIV testing with a specific focus on AA MSM and MSM of all races; $11 million for linkages to care, partner services and prevention in PLWH; $5 million for NCHHSTP's Program Collaboration and Service Integration (PCSI) Initiative; $4 million for capacity-building of health departments and community-based organizations (CBOs) to deliver effective and evidence-based interventions for PLWH and at-risk populations; and $4 million for further enhancements of surveillance and evaluation activities.

Dr. Wolitski confirmed that NCHHSTP would allocate the additional resources in a coordinated and efficient manner to avoid implementation of numerous standalone demonstration projects throughout the country. NCHHSTP also would thoroughly review its internal staff capacity to administer the new dollars. NCHHSTP is attempting to create synergies between the additional resources and existing infrastructures or arrangements that could be utilized. For example, the $27 million increase for HIV testing could be combined with a new program announcement to extend the existing expanded testing initiative. This approach would allow the additional funding to be available to a larger number of jurisdictions and targeted to a greater number of communities.

CHAC applauded CDC on its leadership in launching the new and innovative ACT Against AIDS campaign. However, several members urged CDC to address serious flaws in the initiative. The campaign is severely under-resourced. Some of the AA organizations that were selected and funded for the Leadership Initiative are extremely challenged by addressing the epidemic in the AA gay community or even using the word "gay." For example, one organization developed campaign materials that entirely focused on the epidemic in female heterosexuals despite the much larger prevalence rate in the MSM community. The campaign must not be used to distribute inaccurate information due to the discomfort of these organizations in discussing sex and their lack of knowledge, expertise or competency regarding MSM and other at-risk groups.

Other CHAC members were "aghast" about the selection of the AA organizations for the Leadership Initiative. CDC will need to expend a considerable amount of time, effort and resources to provide training to and build the capacity of some of these organizations. CDC most likely selected the organizations based on their history with the general AA population rather than their expertise with the epidemic at this time. CDC could have allocated these resources in a more efficient manner by selecting its currently funded CBOs throughout the United States to rollout the campaign. These groups would have required minimal training due to their high level of competency, outstanding experience and solid history of serving the target populations.

A number of CHAC members expressed their extreme disappointment that HIV was not defined as a chronic disease in ARRA and ARRA prevention dollars could not be used for HIV. The members noted the contradiction in the legislative language. On the one hand, ARRA prevention dollars can be targeted to diabetes, heart disease and other chronic diseases in the general population. On the other hand, ARRA prevention dollars cannot be targeted to the

same chronic diseases in the aging HIV-positive population. Some members believed that this decision was based on prejudice and racism.

In addition to prevention, CHAC conveyed that continued decreases in HIV prevention dollars also are severely impacting the ability of physicians to provide primary care to HIV-positive patients to assure their long-term survival. CHAC strongly urged CDC to partner with HRSA community health centers (CHCs) to strengthen linkages between the chronic care model and prevention activities, particularly with regard to prevention in PLWH.

In response to Dr. Fenton's request for input, CHAC made two key suggestions on the SDH initiative for NCHHSTP to consider. First, CDC and HRSA should ensure that mental health issues are incorporated into both HIV prevention and care activities to advance the SDH initiative. Mental health is one of the most important factors in linking PLWH to care and patients remaining in care.

Second, NCHHSTP's top priority in the SDH initiative should be to develop solid relationships with the National Medical Association and other non-traditional HIV prevention partners to strengthen collaboration between these organizations and traditional HIV prevention partners. For example, the 14 organizations on the ACT Against AIDS Leadership Initiative could partner with AIDS Education and Training Centers (AETCs) and other traditional partners that have more experience and expertise in HIV prevention.

Drs. Fenton and Wolitski made several follow-up remarks to address CHAC's specific concerns regarding the ACT Against AIDS campaign. CDC acknowledges that the 14 AA organizations serving on the Leadership Initiative are heterogeneous in terms of their individual backgrounds and levels of expertise in addressing and discussing the epidemic. However, both CDC and the organizations would be held accountable for ensuring that resources follow the epidemic in AA MSM and other target populations.

In an effort to standardize the level of technical competency, CDC will conduct site visits to each of the 14 organizations, maintain regular communications with organizational coordinators, and offer numerous training activities. CHAC's concerns on the ACT Against AIDS campaign would be conveyed to CDC staff and a plan would be developed to actively address these issues. CDC would closely collaborate with the organizations over time in designing new materials to provide a more complete and accurate picture of the epidemic.

In terms of CHAC's disappointment regarding the selection of the 14 AA organizations, CDC recognizes that these groups have much less experience than CDC-funded CBOs in addressing the epidemic in at-risk populations. However, CDC acknowledges the critical need to engage non-traditional partners to extend the reach of HIV prevention messages. In an effort to achieve this goal, CDC will allocate $45 million to the 14 organizations over the five-year cycle of the campaign. This investment will include rather than exclude traditional HIV prevention partners. CDC also will conduct a critical evaluation to determine whether this mechanism is appropriate for engaging non-traditional HIV prevention partners.

With respect to CHAC's concern regarding the focus of the campaign on the AA community, CDC has already initiated discussions with its Hispanic/Latino Executive Committee Workgroup to develop recommendations on improving HIV prevention activities for this population. Although the first phase of the campaign is targeted to the AA community, CDC will soon begin establishing new partnerships and expanding current relationships with Hispanic/Latino groups. During the next CHAC meeting, CDC plans to report on its progress in enhancing partnerships and developing activities for the Hispanic/Latino community as well as for gay and bisexual men.

## HAB Director's Report

Dr. Parham Hopson covered the following areas in her update. At the agency level, HRSA's new leadership team includes Dr. Mary Wakefield as the Administrator; Dr. Marcia Brand as the Deputy Adminstrator; Ms. Tina Cheatham as the Senior Advisor to the Administrator; Ms. Judy Andrews as the Acting Director of the Office of Legislation; and Ms. Diana Espinosa as the Acting Director of the Bureau of Health Professions (BHPr). At the bureau level, HAB's personnel changes include Dr. Margarita Figueroa-Gonzales as the new Director of the Division of Community-Based Programs and Ms. Lynn Wegman as the Deputy Director of the Division of Training and Technical Assistance.

Since her appointment as the new Administrator in February 2009, Dr. Wakefield has been focusing on HRSA's six priorities: healthcare reform; participation in ARRA; increased emphasis on the healthcare force; continued expansion of CHCs; reauthorization of the Ryan White HIV/AIDS Program; and other programs. Of the total $28 billion ARRA investment to HHS, $2.5 billion was allocated to HRSA. HRSA will target $2 billion of its ARRA funding to CHCs and the remaining $500 million to health workforce programs.

In March 2009, HRSA awarded $155 million for the care of 750,000 persons at new CHC sites and service areas and an additional $338 million for the care of >2 million persons at 1,128 existing CHC sites. HRSA released guidance for CHCs to submit applications for $1.5 billion that will be awarded to support the construction, renovation and equipment of CHCs, including HIT. HRSA must award these funds by September 30, 2009.

Dr. Wakefield is committed to expanding care for PLWH in CHCs and ensuring that PLWH have access to the full range of HRSA programs, including CHCs. At this time, 91% of CHCs provide HIV testing and counseling onsite and 10% of CHCs receive Part C funding. HIV services are available at both Ryan White HIV/AIDS-funded and non-funded sites. HRSA will compare lists of CHCs and subcontractors that receive Parts A and B funding to determine the actual reach of Ryan White dollars in CHCs. Dr. Parham Hopson plans to report the results of this analysis during the next CHAC meeting.

Of ARRA funding for the health workforce, HRSA will allocate $300 million to expand the National Health Service Corps and $200 million to Titles VII and VIII health professions

programs with an emphasis on nursing. Of the $1.1 billion ARRA investment for CER, $400 million was allocated to the HHS Office of the Secretary, $400 million was allocated to NIH, and $300 was allocated to AHRQ. ARRA authorized the establishment of a Federal Coordinating Council (FCC) to help coordinate research and guide investments in CER with ARRA funding. The FCC is represented by HHS, the Department of Veterans Affairs (VA) and Department of Defense.

The FCC will consider the needs of populations served by federal programs, including persons with diabilities and minority populations; consider opportunities to build and expand current investments and priorities; and provide input on priorities for the $400 million CER fund under the control of the HHS Secretary. The FCC will not recommend or draft clinical guidelines for payment, coverage or treatment; instruct physicians or any other providers on practicing medicine; and mandate specific care.

The FCC held two listening sessions to provide an opportunity for stakeholders in the disability and HIV/AIDS communities to give feedback on potential CER projects. The FCC will convene additional listening sessions and will capture input from stakeholders in its report that must be submitted to Congress by June 30, 2009. Dr. Parham Hopson encouraged CHAC to provide her with suggestions on other potential CER projects for the FCC to consider.

HRSA's FY2009 budget is $7.2 billion, while the President's FY2010 budget request for HRSA is $7.1 billion. HAB and the Bureau of Primary Care represent >50% of HRSA's entire budget. The remainder of the President's FY2010 budget request for HRSA includes ~$877 million to the Bureau of Maternal and Child Health, ~$716 million to BHPr, ~$125 million to the Office of Rural Health, ~$166 million for healthcare systems, and ~$122 million for clinical recruitment and services.

The President's FY2010 budget request of ~$2.3 billion for the Ryan White HIV/AIDS Program reflects an increase of ~$54 million. The $815 million budget of the AIDS Drug Assistance Program (ADAP) and Part A funding of $663 million to eligible metropolitan areas and transitional grant areas (TGAs) represent the two largest parts of the FY2009 Ryan White appropriation.

A number of activities are underway at HAB. CDC transferred funding to HAB to support the CDC/HRSA HIV testing and training initiative. HAB awarded this funding for AETCs to conduct training on HIV testing in medical care settings. As of March 2009, HAB provided >2,500 training sessions and trained >40,000 providers with a focus on CDC's new HIV testing recommendations. At this time, >527 sites have implemented some form of routine testing. All of the provider tools AETCs developed and disseminated for use in a variety of medial settings are available on the online National Resource Center at no cost.

HRSA launched the new "Health Workforce Information Center" web site in January 2009 and will convene "The Healthcare Workforce Crisis: A Summit on the Future of Primary Care in Rural and Urban America" on August 8-10, 2009. The 600 national experts who will attend the summit include HRSA grantees, academicians and policymakers. The summit will build on

HAB's HIV workforce study: *Factors Impacting the Retention of Clinical Providers and Other Key Personnel in Ryan White HIV/AIDS Program Settings*. The goal of the study is to provide HRSA and HAB with a better understanding of the extent of HIV-related clinician shortages to inform the identification and implementation of strategies to address these shortages.

The HAB "State HIV/AIDS Resources and Educational Discussions" (SHARED) Initiative includes structured discussions with project officers of Parts A, B, C, D and F programs and data and education/training staff to identify care and treatment issues and strategic interventions. Over a period of nearly two years, HAB reviewed all 56 states and territories and identified seven universal issues: access to care, new populations, coordination at the grantee level, HIV workforce, ADAP, data collection, and late entry into care. Dr. Parham Hopson asked CHAC to explore strategic interventions that could be implemented to address these issues.

HAB began collecting client-level data in January 2009 and has required grantees to submit the first reports in June 2009. However, only grantees and providers of ambulatory outpatient medical care or medical/non-medical case management will be required to submit clinic reports. HAB developed and disseminated a number of resources and tools to assist grantees in client-level data reporting.

The Client-Level Data Technical Assistance Triage Committee was established. The technical assistance process and other resources for grantees were posted on the Technical Assistance Center web site. Numerous webcasts that addressed issues confronting grantees and providers were broadcast, recorded and archived. The "Ryan White Services Report Discussion Board" was launched in March 2009. Capacity building funds for client-level data reporting were set aside for Parts A, B, C and D grantees.

HAB completed four studies in 2009 in response to evaluations and reviews the U.S. Government Accountability Office (GAO) and the HHS Office of Inspector General (OIG) conducted on Part D administrative expenses; barriers to program integration in the Minority AIDS Initiative; procurement mechanisms and procedures in the President's Emergency Plan for AIDS Relief (PEPFAR); and Part B ADAP compliance among states with the payer of last resort requirement. HAB's ongoing GAO and OIG studies are focusing on the 2009 reauthorization of the Ryan White HIV/AIDS Program; 75%/25% core medical services compliance and waiver process; and a PEPFAR audit.

HAB posted group 3 of the core clinical performance measures on its web site and plans to release the final measures in the fall of 2009. HAB is currently reviewing public comments on the draft set of HIV performance measures in four areas: ADAP, case management, oral health, and system-level measures. HAB is conducting two quality initiatives under its National Quality Collaborative.

The Cross-Part Collaborative was awarded to five states to strengthen statewide coordination across all Ryan White parts and align quality management goals. The TGA Initiative was awarded to five newly-funded TGAs to provide intensive technical assistance on building their quality management programs. HAB's group 1 performance measures are being used in both

of the quality initiatives to help grantees build an infrastructure around quality and collect data for quality.

Reauthorization of the current Ryan White law will sunset on September 30, 2009. Dr. Wakefield has met with Congressional staff in both the House and Senate to emphasize the critical need for reauthorization. Moreover, the new Administration has solicited HAB's input on reauthorizing the law. Dr. Parham Hopson encouraged CHAC to provide her with suggestions on specific activities to include in the law.

Dr. Parham Hopson provided additional details on HRSA's HIV care and treatment activities in response to CHAC's specific questions comments. HRSA is exploring strategies to use a portion of the $4 million increase in the proposed FY2010 budget to address concerns regarding the health workforce. One approach HRSA is considering is to require National Health Service Corps providers to spend time in AETCs to increase their competency in HIV care.

HRSA is continuing to harmonize and coordinate workforce training. Under the "4.5 Training Center Initiative," HRSA's AETCs link with training centers of other federal agencies. However, the data reporting systems of training centers will not be merged because Congress requests different information from different federal agencies.

CHAC applauded Dr. Parham Hopson on her new rank as Rear Admiral (Upper Half) beginning on February 1, 2009. She is now the only two-star nurse in the entire Commissioned Corps. The CHAC members made a number of comments and suggestions on HRSA's ongoing HIV care and treatment activities.

- Intermountain Health Care in Salt Lake City is developing a model to integrate mental health practice and primary care. HAB should review and make efforts to replicate the model to link mental health and HIV care in CHCs.
- HAB should urge CHCs to thoroughly review the medical records of patients to determine factors associated with late entry into care.
- HAB should engage state health departments in the SHARED Initiative to facilitate better harmonization of HIV care and treatment efforts between federal and state levels. The SHARED discussions also should reflect input from patients regarding their personal experiences in receiving HIV care and treatment at CHCs in various states.
- HRSA should present the following issues to the FCC as potential CER projects: (1) "contingency management" in which cash or other incentives are offered to change behaviors and (2) emerging models for HIV care, such as group clinics, patient navigation and patient-centered medical homes. However, research should be conducted to evaluate CER models in terms of their cost-effectiveness and ability to address late entry into care or retention in care.
- HAB should determine whether a portion of the $500 million ARRA investment for CHCs can be used for HIV and STD screening at these sites.
- HHS should assure that HIT systems address the pressing need for more timely surveillance activities to respond to rapidly evolving epidemics. Data that are currently collected to drive initiatives frequently are one or more years old.

- HRSA should emphasize to Congress the role of the Ryan White HIV/AIDS Program as an outstanding model of integrated outpatient care.
- HHS should use the new Administration as an opportunity to renew previous efforts for a representative of the Centers for Medicare and Medicaid Services (CMS) to serve as an *ex-officio* member on CHAC. CMS representation is critical to address the issue of Medicaid and Medicare reimbursement for HIV care and treatment.

## Update on HIV Testing

Dr. Bernard Branson, Associate Director for Laboratory Diagnostics in DHAP, reported that CDC identified seven key goals and activities to support HIV testing and promote expanded testing. CDC's progress in these seven areas is summarized below.

One, implementation guidance would be developed to support routine HIV testing in a variety of healthcare settings. CDC collaborated with partners in specific disciplines to develop implementation guidance for correctional facilities, CHCs and emergency departments (EDs). Although HIV testing has been recommended in STD clinics and substance abuse treatment centers for >20 years, implementation guidance has not yet been developed for these settings.

Two, adoption and implementation of the 2006 Recommendations would be monitored. CDC awarded a two-year contract for the "Assessment of HIV Testing in Clinical Settings" (AHITS) Project to monitor and evaluate HIV testing. The goals of the project are to establish a baseline, perform follow-up analyses of longitudinal surveys, and assess barriers, strategies and successes in programmatic activities conducted by grantees. The Office of Management and Budget has delayed the administration of a survey of projects in clinical settings.

The baseline report from the 2002-2006 National Health Interview Survey showed that the percent of persons who had been tested in the prior year remained stable but the number of persons reporting they had ever been tested did not increase. This finding most likely indicated that the same persons were being retested. However, the percent of persons who ever received an HIV test increased from 39.9% in 2006 to 41.3% in 2007. The percent of persons who received an HIV test in the preceding 12 months slightly increased from 10.4% in 2005 to 10.7% in 2007. Recent data for the first nine months in 2008 also shows evidence of improvement over the 2007 data.

Based on data collected from 34 states with confidential HIV reporting, the estimated cases of HIV/AIDS increased by 15% from 37,164 cases reported in 2004 to 42,655 cases reported in 2007. Due to the variation in HIV testing and data collection among states, CDC cannot attribute the 15% increase in HIV/AIDS cases to the effects of testing at this time.

Three, reimbursement mechanisms would be promoted. Professional associations developed the CPT-ICDM coding guide for providers. CDC partnered with Medicaid medical directors and the Managed Care Forum to promote HIV testing. CMS recently announced plans to conduct

national coverage determination for Medicare reimbursement of HIV screening. However, no progress has been made to date to provide coverage for HIV screening under the Federal Employees Health Benefit Plan.

Of 11 large healthcare plans, all have established policies to reimburse for targeted HIV screening and six established reimbursement policies for routine HIV screening. California passed state legislation requiring insurers to reimburse for HIV testing regardless of the diagnosis code. Similar state legislation was introduced in Texas and Washington, DC, and national legislation was reintroduced to Congress. A number of professional associations, including the American College of Physicians and American College of Obstetricians and Gynecologists, have issued specific HIV screening recommendations to their respective memberships that is consistent with CDC guidelines in whole or in part.

Four, an inventory of state laws and regulations would be created and changes in state laws would be monitored. Restrictions on HIV testing and signed consent requirements were removed at the federal level for the VA and at the state level in 11 states. Seven states proposed legislation to remove written consent requirements that were not enacted in 2008. Massachusetts is the only state with no legislative action to remove written consent requirements in 2008 or 2009. To date, eight states have introduced legislation in 2009.

Five, training of healthcare professionals would be coordinated with federal partners and other groups to support HIV screening in clinical settings. CDC held eight regional strategic planning workshops for EDs with 748 attendees representing 165 hospitals. CDC is conducting follow-up with the participating institutions at six months and one year. Results from the initial hospitals participating in the workshops showed that 19 of 24 had established programs for HIV screening in EDs.

CDC also (1) established an interagency agreement with HRSA for AETCs to provide training to non-HIV clinicians; (2) formed a strong relationship with the AETC National Resource Center; (3) produced four web-based continuing medical education courses for nurses, emergency physicians, primary care providers (PCPs) and public health professionals; (4) published supplements on HIV testing in peer-reviewed journals; and (6) funded a number of professional organizations to promote extended HIV screening in their respective constituencies.

Nurses, nurse practitioners and physicians represented the vast majority of the 40,152 providers who received training on HIV screening from AETCs from September 2006-June 2008. CDC's revised recommendations for HIV testing in healthcare settings and related HIV testing resources are available on web sites of several professional associations. A referral hotline and consultation is available through the National Clinicians Consultation Center for clinicians, particularly those with limited familiarity in HIV management.

Six, strategies that improve follow-up care of persons who receive a positive HIV test result would be promoted. CDC established referral databases with three professional societies. The National Clinicians Consultation Center is co-funded by CDC and HRSA and serves as a pool of experienced clinicians. CDC and the NIH Adolescent Trials Network have a memorandum of

understanding for referral and case management to assure linkages to care for newly-identified cases 18-24 years of age. CDC is planning to evaluate entry into care by linking laboratory reporting of CD4 and viral load data to the HIV/AIDS Reporting System.

Seven, social marketing campaigns would be launched to promote HIV screening in clinical settings. CDC's formative research with providers showed that fear of offending patients was the primary barrier to recommending an HIV test. CDC developed two social marketing campaigns in an effort to overcome this barrier. The "HIV Screening: Standard Care" campaign promotes HIV testing in acute care, inpatient and primary care settings. The "One Test, Two Lives" campaign promotes HIV testing in pregnant women. CDC will convene a consensus-building meeting in June 2009 to promote HIV screening during hospital admission.

CDC funded seven national organizations through September 2009 to promote HIV testing in a variety of settings, including EDs, STD clinics and substance abuse treatment centers. These organizations also are funded to develop and disseminate HIV testing materials and implementation guidance; conduct evaluations; administer surveys; and offer web-based continuing medical education courses.

CDC awarded cooperative agreements to 25 states to achieve the HIV testing goals of testing 1.5 million persons per year among populations disproportionately affected by HIV, primarily AAs, and identifying 20,000 new HIV infections per year. Based on data collected from 21 grantees from October 2007-September 2008, 64% of all 446,503 persons tested were AAs and 70% of 3,986 new HIV infections identified were among AAs.

The number of HIV tests performed by grantees dramatically increased from 87,038 in October 2007-March 2008 to 732,421 as of February 2009. A significant increase also was seen in the cumulative number of HIV-positive tests from 983 in October 2007-March 2008 to 9,461 in February 2009. EDs, STD clinics and CHCs accounted for the top three venues with the highest percentages of both HIV testing overall and HIV-positive tests. CDC has continued to fund the jurisdictions in 2009, but unexpended dollars will be reallocated to grantees that are most productive in HIV testing. However, no funds will be allocated in 2009 for the interagency agreement with HRSA for the AETCs or in support of national organizations.

CDC performed an analysis of currently available assays with 15 seroconverter panels that showed great variability in sensitivity for early infection. Two random access chemiluminescent assays that detect HIV 1/2/O have received FDA approval: the third-generation Centaur eHIV test approved in July 2006 and the third-generation Ortho Vitros aHIV test approved in March 2008. GenProbe APTIMA is a qualitative HIV-1 RNA assay that was approved in September 2006 as an aid to HIV-1 diagnosis of acute infection in antibody-negative persons. The assay also was approved for confirmation of HIV-1 infection in antibody-positive persons when the result is positive. However, 5%-7% of enzyme immunoassay (EIA)-positive/Western blot-positive specimens may test negative for HIV-1 RNA; thus, EIA-positive, Aptima-negative specimens require further testing for confirmation. Random access tests are designed to store various assays on-board the analyzer and provide results in ~60 minutes.

CDC has been partnering with professional organizations to identify new combination tests for confirmatory algorithms to assist in resolving issues related to the less sensitive Western blot test. CDC and the Association of Public Health Laboratories recently released a status report on this analysis with supporting data on point-of-care and laboratory algorithms. Additional data collection for validation of the algorithms is underway.

CDC identified both advantages and disadvantages with pooled RNA screening for early HIV infection. One the hand, the assay detects HIV earlier at its most infectious state. On the other hand, the cost and turnaround time of the assay are higher, particularly with pooling. CDC conducted an acute HIV infection study that used 16 specimen, one-stage pooling for RNA testing in the counseling and testing sites in the entire state of Florida and STD clinics in Los Angeles. The third-generation Bio-Rad 1-2 Plus O assay used in Florida and the Vironostika EIA used in Los Angeles detected similar prevalence rates, but considerably more acute infections were detected in Los Angeles because of the longer window period of the Vironostika assay. Retesting of the Los Angeles specimens with a more sensitive third-generation EIA demonstrated that a significant number of acute infections were missed.

Of 93,939 persons tested in the acute HIV infection study, 31 acute infections were detected at a rate of 3/10,000 in those who were EIA-negative and positive with nucleic acid amplification testing (NAAT). Of persons who were reactive based on both EIA and Western blot testing, 41 would have been missed by RNA confirmatory screening. Of persons who were EIA-negative and NAAT-positive, 13% proved to be false-positive based on NAAT results.

Studies conducted from 2004-2007 in five high-risk/high-incidence areas showed the yield of targeted pooled RNA screening ranged from 0.9%-7.5% in detecting HIV antibody-positive persons. The yield of the assay ranged from 0.05%-1.10% in detecting RNA-positive/antibody-negative persons. North Carolina's recently published study on targeted testing for acute HIV infection showed that targeted pooled RNA screening identified 92% of recent infections when only 50% of the population was tested. All of these studies concluded that testing of acute HIV infection on the basis of specific criteria most likely would produce the greatest benefit and yield.

The "Abbott Architect" is a fourth-generation combination antibody/p24 antigen immunoassay on the horizon. CDC performed analyses to compare the yield of fourth-generation antigen antibody testing and RNA testing. The yield of RNA-positive/third-generation-negative specimens that were detected by fourth-generation EIA ranged from 71%-84% based on one Australian and two CDC studies. CDC's assessment of nine seroconversion panels showed that the antigen test detected acute infection only four days later than RNA screening.

CDC issued an invitation in the *Federal Register* for manufacturers to collaborate on the evaluation of novel or commercially available assays developed outside the United States. In response to this invitation, CDC will evaluate a number of assays: the multi-analyte rapid test; fourth-generation antigen/antibody combination rapid test; multi-analyte HIV/HCV test; Dual Path Platform screening tests with increased sensitivity in oral fluid and blood; Dual Path Platform confirmatory test with multiple bands analogous to Western blot testing; and point-of-care fingerstick NAAT.

The application for the Unigold Recombigen home HIV test was abandoned. The shelf life of the OraQuick home HIV test was increased to 12 months, which makes it a more viable candidate as an OTC test. Phase II clinical trial data with untrained users of the OraQuick test were submitted to the Food and Drug Administration (FDA). A study that is in press analyzed the relationship between price and prevalence of home HIV tests. The study showed that infected persons would be less likely to afford more expensive home HIV tests.

A 2009 published study compared the use of home HIV tests to screen sexual partners versus condom use among MSM. The study showed that the reduction in risk depends on both prevalence and incidence. The home HIV test would lower the risk of infection by 8%-18% versus no condom use. The risk of infection was lower with condoms if condoms were used in at least 50% of sexual encounters with 8.4% prevalence among partners. The risk of infection was lower with the home HIV test unless condoms were used in at least 68% of sexual encounters with 20% prevalence among partners.

Overall, substantial progress has been made with the expansion of HIV screening. Numerous alternatives are under evaluation for improved detection and confirmation of HIV infection. However, the timeline for home HIV tests remains uncertain.

Dr. Branson provided additional details about CDC's HIV testing activities in response to CHAC's specific questions and comments. Repeat HIV testing is still important with respect to the window period of infection. As a result, CDC does not plan revise its recommendations on retesting at this time. CDC was disappointed with the data on notification of partners with acute infection due to the lengthy time required to locate partners. CDC is now analyzing the cost-effectiveness of notifying partners with acute infection.

CDC is closely collaborating with the American Association of Medical Colleges to incorporate HIV testing into training programs for residents. CDC is making efforts to establish a new standard for the use of its implementation guidance in correctional facilities. CDC will publish an article in the *Morbidity and Mortality Weekly Report* (*MMWR*) in June 2009 on HIV testing rates on young persons by race. The data showed that HIV testing rates were higher among Hispanic men and women compared to non-Hispanic whites. Non-Hispanic blacks had the highest HIV testing rates by race.

CHAC commended CDC on its extensive partnerships with professional organizations to widely promote HIV testing and its substantial progress in HIV screening overall. The CHAC members made two key comments for CDC to consider to further enhance its HIV testing activities. First, CDC should collect data to support the development of guidance on repeat HIV testing for persons at average risk.

Second, CDC should establish stronger relationships with medical and nursing schools to emphasize the importance of HIV testing to residents and other providers in training. CDC also should approach HRSA to discuss the possibility of eliminating the exclusionary provision in Education and Training Centers of not being able to target medical and nursing school students.

## Overview of the White House Office of National AIDS Policy (ONAP)

Mr. Jeffrey Crowley, Director of ONAP and Senior Advisor of Disability Policy, thanked the CHAC members for their continued commitment and valuable contributions to HIV/STD prevention and treatment. He recognized that several constituencies were disappointed with the funding levels and lack of new resources for domestic HIV/AIDS. However, the Administration made a good faith effort in addressing the domestic epidemic by allocating $53 million in new dollars to CDC for HIV prevention and $54 million in new dollars to HRSA for the Ryan White HIV/AIDS Program. Moreover, ONAP is committed to taking advantage of existing HIV/AIDS resources, such as the HHS Office of HIV/AIDS Policy, CHAC and the President's Advisory Council on HIV/AIDS (PACHA).

President Obama is creating unique opportunities in this area. The White House partnered with CDC to launch the ACT Against AIDS Campaign to focus significant attention to the domestic HIV/AIDS epidemic. The President is demonstrating leadership on global health issues by committing $51 billion to PEPFAR over the next six years. However, the strong focus on PEPFAR over the past six years might have contributed to decreased emphasis on domestic HIV/AIDS.

President Obama made a strong commitment to addressing stigma of HIV/AIDS and directed federal agencies to focus their time, attention and resources to populations at highest risk and communities with a disproportionate burden of the epidemic. The President emphasized the critical need for HIV/AIDS resources to follow the science.

ONAP is currently being staffed to conduct domestic HIV/AIDS and disability activities and will use new media and technologies to implement these initiatives. Mr. Crowley has established three key priorities for ONAP. First, HIV prevention will be reemphasized due to the neglect in this area over the past few years and the need to take advantage of existing opportunities. ONAP will ensure the availability of significant prevention expertise through internal White House staff, CDC, communities and other groups.

Second, healthcare reform will be prioritized and will serve as an important opportunity to provide linkages to HIV/AIDS care. CMS spends 50% of all dollars allocated to the domestic HIV/AIDS epidemic, but the agency is not fully engaged in this initiative at the activity level. CMS and other payers must be included in healthcare reform. However, the White House will not develop healthcare reform legislation.

Third, a National HIV/AIDS Strategy will be developed with three overarching goals of reducing incidence, enrolling all PLWH/AIDS into care, and addressing health disparities. To achieve the goal of reducing incidence, models that were successful in decreasing HIV/AIDS incidence in the United States in the past and best practices in other public health areas will be applied, such as the reduction of tobacco use. The new "test and treat" concept is a bold idea that will be considered as well.

To achieve the goal of enrolling PLWH/AIDS into care, healthcare reform, Ryan White providers, and a new or expanded insurance system will play important roles. To achieve the goal of addressing health disparities, progress that has been achieved in this area will be broadened to make a more significant impact. Efforts will be made to reach consensus on the National Strategy.

Mr. Crowley provided more details on the National Strategy in response to CHAC's specific questions and comments. ONAP is committed to developing the National Strategy through an inclusive process. To obtain broad and diverse input, ONAP will visit various groups and stakeholders throughout the country, create a web site, and utilize new technologies to maintain ongoing communications and broadly engage communities and individuals.

ONAP is discussing the potential role of PACHA in developing the National Strategy and looks forward to receiving advice and recommendations from CHAC through CDC and HRSA. New stakeholders and youth with fresh perspectives on the domestic HIV/AIDS epidemic will be extensively engaged. Federal agencies both inside and outside HHS will play a critical role in developing and owning the National Strategy. ONAP will identify strategic opportunities to involve the President, First Lady and White House senior officials in the National Strategy.

ONAP will be fairly disciplined in prioritizing issues to incorporate into the National Strategy. The project will be routinely monitored during the development and implementation phases. ONAP will utilize the White House Domestic Policy Council to integrate non-HIV/AIDS content areas in the National Strategy, such as justice, regulatory and housing issues. ONAP will make a strong case that even with a new or expanded insurance system, the Ryan White Program must be continued as both a payment source and a valuable resource in reaching, linking and retaining underserved populations in care.

ONAP has been reluctant to establish a new "National AIDS Coordinator" position due to budget restrictions and bureaucratic issues. However, lessons learned and successes with the Global AIDS Coordinator for PEPFAR will be thoroughly reviewed to identify specific models that could be applied to the United States. The Administration will closely collaborate with HRSA to develop its position on extending Ryan White reauthorization.

CHAC applauded Mr. Crowley for providing an extremely informative overview of ONAP and the National HIV/AIDS Strategy. Several CHAC members made suggestions for ONAP to consider in developing the National Strategy.

- The National Strategy should be developed with a vision to create a sense of urgency for domestic HIV/AIDS and address this issue with an entirely new approach. The federal government should replicate its rapid and coordinated response to the H1N1 influenza outbreak to respond to the domestic HIV/AIDS epidemic.
- The National Strategy should be developed with a strong culturally-competent component to meet the needs of lesbian, gay, bisexual and transgender health issues.

- The National Strategy should be used as a tool to reframe the current disease-oriented approach to more broadly promote health.
- The National Strategy should place strong emphasis on stigma because this issue prevents persons from being tested and serves as a barrier to PLWH obtaining care and disclosing their infection to partners and family members. The Ryan White Program should be widely publicized as a solid model in creating a stigma-free environment for PLWH/AIDS.
- The National Strategy should not be used as a mechanism for communities to compete for funding. A comprehensive approach should be taken to identify new HIV/AIDS cases in all populations.
- The National Strategy should include a strong recommendation for federal agencies to develop a single coordinated and integrated HIV/AIDS data reporting system.

## Panel Presentation on CDC's Syphilis Elimination Activities

**Dr. John Su**, of DSTDP, presented data from the STD Surveillance Report on the epidemiology of syphilis in the United States in 2007. Primary and secondary (P&S) syphilis rates markedly decreased from 1990-2000, but began to increase in 2001. By gender, MSM accounted for ~66% of P&S syphilis cases. By race/ethnicity, AAs accounted for the highest P&S syphilis rates. Among males 15-19 years of age, African American males accounted for the largest increases in P&S syphilis rates.

By sexual orientation, AA women, AA heterosexual men and white MSM accounted for the highest case counts of P&S syphilis. Among MSM, non-white MSM account for more P&S syphilis than white MSM. By age, men 25-29 and 35-39 years of age, women 20-24 years of age, and AA MSM 15-29 years of age accounted for the highest P&S syphilis rates. By source of information, STD clinics reported the most P&S syphilis cases in women and heterosexual men, while private physicians reported the most cases in MSM. P&S syphilis rates in women and congenital syphilis cases have been increasing since 2005.

By region, the South accounted for the highest P&S syphilis rates in women and AA MSM. A recent *MMWR* article reported that heterosexual men and women accounted for the most P&S syphilis cases in Jefferson County, Alabama. CDC hopes to begin collecting risk factor data for P&S syphilis with a common interview record that is being developed with colleagues. Overall, MSM accounted for 66% of new syphilis infections. Many MSM are non-white and likely to be younger. Private physicians reported the most P&S syphilis cases among MSM. Female and congenital sypnhilis rates are rising, particularly in the South.

**Ms. Jo Valentine**, of DSTDP, presented a progress report on CDC's Syphilis Elimination Effort (SEE). The SEE goals are to invest in and enhance public health services; prioritize and target interventions; and strengthen accountability and implementation of activities. Challenges for SEE include level funding to respond to new epidemics while maintaining successes and gains

achieved in the first targeted communities. However, level funding is actually equivalent to a decrease for many programs and project areas.

Other challenges for SEE include the need to assure quality surveillance, epidemiologic analysis, and the availability of quality clinical, laboratory and partner services in both public and private sectors. Multiple factors associated with the risk for syphilis and other STDs require tailored interventions for different populations and evaluation of activities.

DTSDP developed a funding formula to address issues related to level funding. Beginning in FY2008, a project area was defined as a "high morbidity area" (HMA) if the area experienced either >100 P&S syphilis cases or a P&S syphilis case rate >2.2/100,000 in a calendar year. Project areas that no longer meet the criteria for HMA status receive base funding of $150,000 for two years during the post-HMA transition period.

DSTDP developed activities for SEE in six categories: evidence-based action plans (EBAPs), training and staff development, enhanced surveillance, partner services, laboratory services and tailored interventions. Specific activities include:

- program evaluation, technical assistance and support;
- a monthly webinar series;
- SEE coordinator letters;
- technical assistance assessments;
- quality assurance methods for adult and congenital syphilis surveillance;
- weekly meetings with the Syphilis Data Sharing Group;
- data presentations and discussions;
- a new common interview record;
- recommendations for partner services for HIV, syphilis, gonorrhea and chlamydia;
- national guidelines for web-based STD and prevention;
- a rapid syphilis test;
- Phase III formative research on the Ulcer Recognition Campaign for MSM;
- Internet guidelines for STD prevention and partner services; and
- formative research on AA MSM.

The vast majority of the 2009 EBAPs focus on MSM as the target population and partner notification and screening as the top two types of interventions. The 2008 Pareto Group webinar topics addressed syphilis screening using treponemal tests; syphilis performance measures; syphilis in Tennessee; a clinician's resource for STD prevention in MSM; a mid-term progress report and update on SEE; prediction markers for syphilis; and syphilis reactor grids and trends.

Results of the SEE mid-term progress review are highlighted as follows. Federal resources have declined. Traditional interventions, such as outreach screening and partner services, have been less effective. However, infectious syphilis is still at a very low rate, easily preventable and readily curable, and concentrated in certain affected communities and groups. Grantees

should apply local surveillance and research data to develop evidence-based strategies. Local SEE activities that are flexible and allow for a rapid response to evolving epidemics should be conducted. Collaborations should be established with affected communities and other providers to integrate SEE in other STD and HIV prevention programs.

The 1999 *National Plan to Eliminate Syphilis from the United States* defined syphilis as a social disease. The same populations that are affected by syphilis also are impacted by chlamydia and gonorrhea. As a result, messages should be combined to promote general community health.

DSTDP will consider a number of important issues to advance SEE. Multiple epidemics require diverse approaches. Healthcare reform will impact the delivery of STD services. Expanded public health partnerships are needed to reach persons in a variety of healthcare settings, such as CHCs and AIDS Services Organizations. Program evaluation is critical to ensure effecive appliction of limited resources. A new conceptual framework that promotes sexual health and health equity should be developed to engage new partners in addressing STD prevention and control.

**Dr. Ronald Ballard**, of DSTDP, described the development of a dual point-of-care (POC) serologic test for syphilis. The serological diagnosis of syphilis requires the detection of two distinct antibodies. Non-treponemal tests are non-specific and detect heterophile antibodies to an antigen-containing cardiolipin that is released from treponemes and damaged host cells. Non-treponemal antibodies are the best indicators of active infection and decline with successful treatment. Treponemal tests are highly specific and detect antibodies directed against *Treponema pallidum* or specific proteins of the organism. These tests remain positive for life even after the provision of effective treatment.

CDC collaborated with a commercial partner to develop a rapid, inexpensive and qualitative POC test for syphilis that would not require expertise in interpreting results and would serve as both a screening and confirmatory test in a lateral flow format. The assay can be performed at non-conventional sites on whole blood, serum or plasma with as little as 5 µl of blood. The results can be read within 15 minutes.

Performance characteristics of the POC test include 91.3% sensitivity and 100% specificity with a non-treponemal line and 92.4% sensitivity and 91.5% specificity with a treponemal line. Performance characteristics of the lateral flow dual POC test for syphilis when compared to the rapid plasma regain test and *Treponema pallidum* particle agglutination assay include 90.7% sensitivity and 99.5% specificity. The DPP™ Handheld Reader measures the reflectance of individual test lines and results in less subjectivity in reading the test, particularly in settings with poor lighting.

The POC test will be further evaluated in laboratory-based and clinical studies to confirm its performance characteristics as part of the WHO STD Diagnostics Initiative. FDA approval is anticipated in early 2010 for the test to be waived under Clinical Laboratory Improvement Amendments for use by non-laboratorians. Development of the test is a major advance in

expanding syphilis serologic screening and providing treatment at the initial contact with health authorities. The test will be further refined to develop a semi-quantitative version that could be used to monitor the efficacy of therapy.

CHAC made comments and suggestions in two key areas for CDC to consider in refining its syphilis elimination activities. First, CDC should update its outdated STD surveillance mechanisms and strategies to improve the timeliness of data and better respond to these diseases. For example, DSTDP presented 2007 data from the STD Surveillance Report on the epidemiology of syphilis in the United States as "preliminary" results. However, these data are a critical component in informing the development of policy and interventions. CDC should attempt to leverage ARRA funds that were allocated to HHS for HIT to support this effort.

Second, CDC should extensively involve HIV care providers in SEE to optimize management of STD patients and promote prevention in PLWH. This approach would provide another opportunity to enhance synergy between HIV and STD programs and strengthen collaborations between Prevention Training Centers and AETCs.

DSTDP staff made several follow-up remarks to CHAC's comments and suggestions. DSTDP agreed with CHAC that the timeliness, completeness and infrastructure of CDC's STD surveillance system need to be improved, particularly to produce national real-time data on risk factors. DSTDP has prioritized an effort to closely collaborate with its funded project areas to use local STD data faster and better with new technologies.

Preliminary data collected from large metropolitan areas in 2007 indicated that HIV/syphilis co-infection rates were 50%-60% overall and 50%-60% in young AA MSM 15-24 years of age. Preliminary 2007 data showed an escalation in P&S syphilis among young AA MSM, but CDC plans to finalize its analysis of 2008 data over the next few weeks to obtain a clearer picture of current trends.

DSTDP increased its outreach to and mobilization of HIV care clinicians, private providers and CHCs to raise awareness of the need for STD screening among providers outside of STD clinics. However, DSTDP recognizes the need to develop strategies to address disparate billing systems, insurance codes and other issues related to providing care to HIV/syphilis co-infected patients. DSTDP relies on CDC's Prevention Training Centers to deliver educational messages on the need to consider sexual health issues of patients in a more comprehensive and holistic manner.

## Update on HIV, STD, Hepatitis and TB Prevention in Correctional Settings

**CAPT Laurie Reid** is a Public Health Advisor in DHAP and Co-Chair of the NCHHSTP Corrections Workgroup. She explained that the Workgroup was formed in 2007 to effectively plan, implement, coordinate and evaluate NCHHSTP's strategic priorities and imperatives as well as to serve as an avenue of communication for correctional activities among the divisions.

Bureau of Justice Statistics data showed that of ~2.3 million persons who were in custody as of June 30, 2007, ~1.5 were in state and federal prisons and ~781,000 were in local county jails. These data excluded ~120,000 persons who were incarcerated in military, Indian Country, juvenile or U.S. Immigration and Custom Enforcement facilities. In the United States, the average jail stay is 30 days and the average prison stay is 2.5-3 years.

CDC convened the "Corrections and Public Health Consultation: Expanding the Reach of Prevention" in March 2009 to provide an opportunity for ~100 subject-matter experts from the corrections, public health, academia and community sectors to develop more effective strategies to address important issues for incarcerated persons, including health disparities in HIV/AIDS, viral hepatitis, TB and STD. Representatives from the Association of State and Territorial Healthcare Officials and the National Association of County and City Health Officials (NACCHO) also attended the consultation to provide CDC with input from a local perspective.

CDC established five key goals for participants of the consultation. NCHHSTP priorities would be developed to enhance the provision of infectious disease prevention services. Suggestions would be provided for continuity of care and linkage back to the community. An adaptable strategy would be created for reducing the burden of infectious disdease within correctional settings.

Suggestions that could guide policies, program and research efforts would be provided. Models of best practices for integration of improved public health programs into correctional settings would be identified. The consultation was structured with three breakout sessions: (1) the role of public health and prevention within correctional settins; (2) public health principles and public safety responsibility of program integration; and (3) best practices and best outcomes.

The consultation participants made several preliminary recommendations for CDC to consider. Expertise among correctional health staff should be identified and acknowledged. National surveillance and other data collection methods should be improved to promote consistency in variable measurements for linking data across jails, state and federal prisons. Methods for tracking released inmagtes should be considered. Repeat offenders might be incarcerated in various disconnected correctional systems.

Prevention programs and behavioral interventions should be pilot tested in correctional facilities and evaluated for effectiveness. Special studies should be conducted to achieve three key goals: (1) explore the relationship between diseases in correctional facilities and communities to which inmates belong; (2) explore the relationship between disease risk behaviors and criminality; and (3) determine disease progression among incarcerated and released populations.

The focus on community corrections should be increased. Limited public health systems are operating at this time for follow-up to continue medical care after inmates are released and placed on parole or probation. Discharge planning should be considered at intake as a critical role for public health systems. Funds should be targeted to correctional research. Grant writing

workshops should be convened to help correctional facilities become more competitive in responding to requests for applications.

Collaborations should be established to develop public health training sessions for correctional officers. A new "Office for Correctional Health" should be established to help integrate data collection, programs and service support for chronic and infectious disase prevention. This office could help to eliminate service duplication and identify gaps in coverage. The consultation was very well received overall. The participants were given thumb drives with the most recent corrections-related information CDC has produced to date. CDC also demonstrated its new corrections web site.

**Dr. Anne Spaulding**, of Emory University, described HRSA's "Enhancing Linkages to HIV Primary Care in Jail Settings" (EnhanceLink) Initiative. HRSA established an Evaluation and Support Center (ESC) in September 2006 in preparation of funding ten demonstration sites, including one CHC in Springfield, Massachusetts, to conduct the EnhanceLink Initiative for four years beginning in September 2007. The sites are funded to develop innovative methods for managing HIV-positive persons who leave jail settings.

The rate of confirmed AIDS cases in state and federal prisoners was 2.5 higher than cases in the non-incarcerated U.S. population at the end of 2006. AIDS accounted for nearly 5% of deaths among state inmates in 2006. In the United States, ~14% of persons with HIV pass through correctional facilities each year. Gender and regional differences in HIV rates in correctional settings greatly vary, but facilities in the Northeast and Southeast have the largest number of HIV cases.

Local jails have a large concentration of HIV cases due to their high rates of admissions and turnover. In 1989, one in four women incarcerated in Rikers Island jail was HIV-infected. Of all HIV tests performed in Rhode Island, 33% of positive tests were detected during routine jail screening. In 2007, local jails had 13 million admissions. Of all admissions to local jails, 50% leave within 48 hours. These data demonstrate the critical need for rapid screening of detainees.

The EnhanceLink demonstration sites will conduct a variety of activities during the project cycle. HIV screening will be performed and cases will be diagnosed to determine the feasibility of rapid testing. Continuity of care programs will be developed with discharge plans and post-release case management. Clients will have an option of enrolling in the evaluation component as services are provided to avoid "requiring" persons in a vulnerable population to become involved in a research project. However, conducting a rigorous evaluation is a condition of funding for each awarded site. Aggregate and client-level data will be collected to inform the development of policies on HIV in jails. Programmatic and evaluation technical assistance will be provided.

Services provided by four selected sites are described as follows. The Atlanta, Georgia site focuses on men who are HIV-positive and substance abusers in the Dekalb County Jail. This site offers case management, substance abuse treatment, and HIV/AIDS and STD education.

The New York City site focuses on PLWH/AIDS in the Rikers Island Transitional Consortium. This site offers rapid HIV testing, community linkages and court advocacy.

The South Carolina site focuses on men and women detained in the Alvin S. Glenn Detention Center. This site offers rapid HIV testing, linkage coordination, and HIV and substance abuse education. The New Haven, Connecticut site focuses on HIV-positive detainees in the New Haven County Jail and York Correctional Institute for women. This site offers case management, community linkages, buprenorphine treatment and a money management program.

The ESC conducted a multi-site evaluation of the EnhanceLink Initiative by asking research questions to address gaps in knowledge. Aggregate data included administrative data on jail and medical issues. For example, aggregate data were collected to determine the fraction of the eligible population for the interventions that was served. Client-level data included longitudinal individual interviews with clients and reviews of medical charts and laboratory data. For example, client-level data were collected to determine the number and length of linkages that were maintained and specific characteristics associated with successful linkages. Cost data were collected to determine resources that were required to deliver interventions.

Preliminary data from the EnhanceLink demonstration project showed a large volume of HIV testing. The sites performed 1,535 HIV tests with Special Projects of National Significance funding and 4,264 HIV tests in total. All of the sites received 100% of HIV test results. Protocols for HIV testing were consistent with CDC's 2006 recommendations. Acceptance rates of HIV testing were reasonably high and the rate of persons who returned for results were high as well. To date, 116 clients have either completed or are currently completing baseline interviews for client-level data. Additional efforts are underway to identify the most effective testing and case management protocols.

The ESC will continue to disseminate results of the study by posting information on the EnhanceLink web site, publishing papers in peer-reviewed journals, and making presentations at national conferences. To advance EnhanceLink in the future, emphasis will be placed on reaching a wider audience to increase the impact and efforts will be made to coordinate with federal initiatives and sustain the project.

CAPT Reid, Dr. Spaulding and Dr. Samantha Williams, of NCHHSTP, provided additional details on HIV prevention and care in correctional settings in response to CHAC's specific questions and comments. CDC emphasized the importance of focusing on substance abuse and mental health during the Corrections and Public Health Consultation. The final report will capture recommendations that were made in this area.

The ESC needs assistance in determining the best products for the EnhanceLink Initiative, such as a toolkit. However, more research needs to be conducted in addition to developing a toolkit to analyze other types of correctional populations, such as persons who are paroled versus those placed on probation, persons who are released from prison versus those released from jail, and youth who are released from juvenile justice systems. The effectiveness of structural

prevention interventions in these populations should be demonstrated and tools should be disseminated to corrections partners for immediate use.

The most significant barriers to implementing guidance from the consultation or findings from the EnhanceLink Initiative are the competing priorities of "custody" versus "care" in correctional settings and different funding streams for corrections and public health departments in each state. Evaluation and cost data from the EnhanceLink demonstration sites will be published as a key component in expanding and sustaining the project over time.

CHAC made three key suggestions to strengthen the ongoing efforts by CDC and HRSA to enhance HIV prevention and care in correctional settings.

- The ESC should showcase successes with the EnhanceLink demonstration sites as a national mechanism to increase communication with and widely disseminate information to county jail providers, county health organizations and State Associations of County Health Offices.
- The ESC should link the EnhanceLink Initiative to the "Criminal Justice and Drug Abuse Treatment System" that is funded by the National Institute on Drug Abuse. This project has collected a wealth of data on treatment issues for persons who were paroled or placed on probation.
- CDC and HRSA should make efforts to directly manipulate the environment in correctional settings to more widely promote HIV care and prevention interventions.

With no further discussion or business brought before CHAC, Dr. Hook recessed the meeting at 5:26 p.m. on May 19, 2009.

## Update on Challenges and Opportunities to STD Prevention in the United States

Dr. Hook reconvened the CHAC meeting at 8:30 a.m. on May 20, 2009 and yielded the floor to the first presenter.

Dr. John Douglas, Jr., Director of DSTDP, explained that chronic under-funding and the economic recession are challenges to STD prevention, while healthcare reform is a key opportunity in this area. The federal investment in STD prevention increased from $30 million in 1973 to ~$155 million in 2009. However, funding has remained flat and actually decreased by 25% over the past five years when adjusting the investment for inflation of ~22% and population growth from 200 million to 300 million persons.

DSTDP administered a national survey to STD, HIV, laboratory and immunization programs in 2007-2008 to determine state investments in STD prevention. Based on an 85% response rate, the median levels of state funding were calculated at $0.14 per capita for state STD prevention and $34.60 per capita for state public health activities. Of all state public health funding, 0.30%

was allocated to STD prevention. Of all federal funding for STD prevention, $0.60 per capita or 81% in total was allocated to STD prevention.

The Institute of Medicine (IOM) published a report in 1996 entitled *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*. The report emphasized that STDs are hidden from public view because many Americans are reluctant to openly address sexual health issues. The severe impact of the economic recession on states has been well documented in the January 2009 Drudge Report and numerous media articles. Of all states, 50% are facing funding shortfalls at this time.

CDC convened the "National Economic Crisis: Issues and Consequences for State and Local Public Health" Forum in February 2009 to increase knowledge and understanding of the impact of the economic crisis on state and local health officials. A number of important observations were made during the forum. Federal dollars comprise ~50% of state STD budgets on average. Of all states, 33% expect to lay off health department workers in the upcoming year; 60% expect reduced services; 30% expect programs to be eliminated; and 22% expect budget cuts of at least 10% in FY2009.

Based on the severity of budget constraints, states are reconsidering fundamental commitments to public health. For example, Utah is exploring the possibility of eliminating its state department of public health. California decreased its state funding for public health programs by 10.7% from July 2008-August 2009. Reductions across the board required California to cut all state-funded health expenditures by 10%. Cutbacks in California had less of an impact on vaccine and other federally-funded programs and more of an impact on state laboratories and other stated-funded programs.

California imposed a 10% reduction three months into FY2009, but reductions in the remaining nine months will be >10%. Furloughs of state workers in California became effective in February 2009 with strict travel resources. At the local level, >50% of local health departments expect layoffs. NACCHO estimated a total loss of ~7,000 local public health workers nationwide. For example, the Colorado Springs local public health department incorporated its STD prevention program into the family planning program.

DSTDP recently administered a survey to collect more information on the impact of the economic recession on STD prevention grantees. Based on responses by 82% of 65 project areas as of April 24, 2009, 53% had reduced staff; 22% had or were planning furloughs; 51% had hiring freezes; and 87% had cutbacks in services. In the participating project areas, 239 positions had been cut in all categories of jobs. Disease intervention specialists were most severely impacted with 44% of project areas cutting this position.

In terms of reductions or total elimination of services, 91% of the participating project areas cut community-based activities, 87% decreased laboratory services, and 51% reduced partnerships. Estimates show that $61.5 million would be needed to replace cuts in the STD project areas. An article published in *The New York Times* in April 2009 emphasized that local health agencies were further impacted by the H1N1 influenza outbreak. The article cited the

loss of ~$300 million in funding and 7,000 workers in local health departments in 2008 and the loss of 1,500 workers in state public health agencies from July 2008-January 2009.

Overall, serious cutbacks at state and local levels resulting in a loss of STD prevention staff and reduction of services have exacerbated a chronically underfunded situation. The impact of the recession on STD prevention might affect other prevention programs for HIV testing and partner services and hepatitis B virus (HBV) immunization. The H1N1 influenza outbreak worsened the economic crisis and is likely to be heightened in the 2009-2010 influenza season. Although no increase has been seen in reportable STDs at this time, reductions will reduce testing and might weaken surveillance.

With respect to using healthcare reform as an opportunity for STD prevention, ~18% of non-elderly Americans have no health insurance coverage. An *MMWR* article was published in April 2009 on chlamydia screening among sexually active young female enrollees of health plans in the United States from 2000-2007. The article reported that the annual screening rate increased from 25.3% in 2000 to 43.6% in 2006, but slightly decreased to 41.6% in 2007. Chlamydia screening varied by region with a 46% rate in the Northeast and a 37% rate in the South. However, these data do not include 18% of uninsured persons 16-20 years of age or 28% of uninsured persons 21-25 years of age who have less access to care and chlamydia screening.

Two studies published in 2006 and 2008 analyzed the prevalence of chlamydia screening and infection. Both studies concluded that the lack of insurance was associated with lower rates of testing and higher prevalence of chlamydia. Massachusetts has used healthcare reform to improve STD prevention and was the first state to develop an approach to universal access to health care. This mandate resulted in a statewide insured rate of >97%. However, Massachusetts also was the first state to discontinue publicly-funded STD clinic services. The state plans to rely on existing and emerging systems of care and access to partially supplement the loss in capacity.

Massachusetts acknowledges that its safety net services for STD care and sexual health have potential limitations. All persons with health insurance in the state do not have a PCP. Appointment wait times for STD services can be lengthy. Many persons with STD risks will be uncomfortable in using health insurance or discussing their STD concerns with PCPs. A number of PCPs are not trained in diagnosing and treating STDs and do not stock on-hand supplies. PCPs might be primarily focused on individual health rather than community heath.

Massachusetts recognizes that the success of healthcare reform to ensure complete identification of STDs and interrupt chains of transmission will depend on the willingness of patients to use healthcare coverage for STD treatment. The success of healthcare reform also will rely on adequate training, reimbursement and monitoring of PCPs to increase their capacity to fully respond to public health challenges presented by STDs.

A 1997 published study analyzed patients who attended STD clinics in an evolving healthcare environment. In the cross-sectional survey of 2,490 clients who attended five urban STD clinics,

59% had no insurance, 27% had private insurance, and 14% were covered by Medicaid. In terms of healthcare, 50% of the sample had presented to an STD clinic in the past and 81% had presented to a healthcare provider for non-STD services in the previous three years. The study participants cited a variety of reasons for utilizing STD clinic services: 68% for walk-in services, 59% for low or no-cost services, 43% for confidentiality concerns, 40% for convenient locations, and 34% for expert care.

Of the entire sample, 68% still would have presented to an STD clinic for services even if medical care were free. This high rate was based on prior STD clinic care, private insurance or Medicaid, and the lack of an established relationship with a PCP. The study concluded that a more integrated healthcare system with delivery of primary care would be desirable. However, certain traditional core public health functions, including capacity for STD clinical services, would need to be maintained.

Projections were published in March 20008 regarding the public health workforce crisis. The estimates showed that the United States would need 220,000 more public health workers by 2020 to match the 1980 rate and 66,000 more workers to match the 2000 rate. This challenge is compounded by the fact that ~110,000 workers, or 23% of the current workforce, are eligible to retire by 2012. The workforce shortage affects a variety of disciplines, including public health physicians and nurses, epidemiologists, healthcare educators and administrators.

Dr. Douglas concluded his presentation by giving his personal perspectives on priorities for STD prevention in an era of health reform. Emphasis should be placed more broadly on health system reform rather than healthcare reform. Maximizing population health will depend on more factors than access, including social and environmental factors. The focus should be intentionally targeted to prevention to develop a truly cost-effective health system. Attention to the public health infrastructure should be directed to developing formal public health roles and leveraging broad prevention partnerships.

Program evaluation should be bolstered toward more cost-effective, impactful and measurable programs and prioritization of program activities and resources. CER should include a focus on translating, disseminating and scaling-up prevention interventions in addition to clinical services. Strong attention should be directed to replenishing the workforce. Models of universal access to health care should be thoroughly reviewed, such as safety net services for STD care and sexual health in Massachusetts and systems in European countries.

CHAC agreed with Dr. Douglas's observations regarding the critical need to address the workforce crisis in health system reform. Several members pointed out that this issue would be the most significant factor affecting public health at federal, state and local levels over the two years.

CHAC reiterated the importance of a CMS representative serving as an *ex-officio* member to discuss reimbursement of HIV/STD prevention and treatment as well as other public health concerns CHAC has raised over time. The members noted that HIV/STD providers are virtually

forced into a managed care environment and are offered fewer incentives to provide HIV/STD services and care.

CHAC proposed two potential roles for CMS in HIV/STD prevention and care. CMS should develop standards for the public sector that could be applied to managed care plans. CMS should provide guidance to the National Committee for Quality Assurance in creating standards for managed care organizations in the private sector that do not include prevention in public health practice.

CHAC advised CDC to take more proactive and aggressive actions to achieve NCHHSTP's PCSI goals, particularly in the current environment of diminished resources for STD and HIV prevention. The members asked CDC to consider diverting dollars from federally-funded STD clinics that do not perform HIV testing.

## Update on Viral Hepatitis Prevention Activities

Dr. John Ward, Director of the CDC Division of Viral Hepatitis (DVH), announced that CDC conducted a number of activities in recognition of World Hepatitis Day on May 19, 2009. He described DVH's new and ongoing projects to support its four strategic imperatives for viral hepatitis prevention.

To "protect vulnerable populations from infection," DVH issued new guidance in December 2006 that called for universal vaccination of persons in HIV, STD and injection drug use (IDU) treatment settings. Adults with behavioral risks, such as MSM, IDUs and STD clinic clients, accounted for the lowest HBV vaccine coverage and represented 95% of new HBV infections in 2006. Although resources were not allocated for implementation of the guidance, DVH collaborated with internal CDC partners to leverage ~$20 million from Title 317 funds to purchase adult hepatitis B-containing vaccine for distribution in 51 project areas at low or no cost.

The "Adult Hepatitis B Vaccination Initiative" coverage area of 1,793 sites includes 45 states, two cities and four territories. In year 1 of the initiative, grantees administered 232,713 HBV vaccine doses from November 1, 2007-October 31, 2008. Local health departments, STD clinics, jails and prisons accounted for the top four sites that ordered and administered the most HBV vaccine doses. These results demonstrate that year 1 of the HBV initiative was as or more successful than the first year of other immunization programs. In year 2, CDC distributed $16 million to 48 grantees for vaccine purchase only and also awarded a $400,000 contract to NACCHO to formally and independently evaluate the program.

To "prevent disease from chronic viral hepatitis," DVH published recommendations in the *MMWR* in September 2008 for the identification and management of persons with chronic HBV infection. The testing recommendations harmonized DVH's existing guidance and new guidelines for populations with $\geq$2% HBV prevalence, such as foreign-born persons, MSM,

IDUs, PLWH, and persons with immunosuppressive or elevated liver enzyme conditions. The management guidance included recommendations on patient counseling, contact management and care referral.

The screening guidelines were based on the seroprevalence of chronic HBV infection in the risk populations. CDC and other studies show that 33%-66% of 800,000-1.4 million persons with chronic HBV in the United States are unaware of their infections. These data also demonstrated a number of missed opportunities to implement interventions in a variety of clinical settings and emphasized the critical need for provider education to build capacity in detecting HBV cases.

To "monitor viral hepatitis emergence and health burden," DVH initiated the Chronic Hepatitis Cohort Study (CheCS) to understand the impact of care and treatment recommendations on the clinical course of chronic HBV and HCV. CheCS will serve as the first comprehensive longitudinal observational cohort of up to 20,000 patients in the United States. To date, only a limited number of cohort studies of patients with chronic HBV or HCV infection have been designed with complete clinical, demographic and behavioral information.

CheCS will be used to collect perspective real-time and retrospective data from medical records and gather behavioral information from confidential self-administered patient interviews. CheCS is modeled after the successful HIV Outpatient Study Project that was conducted with a 15-year cohort and resulted in a number of important publications on HIV/AIDS clinical epidemiology, care and treatment. The six CheCS sites will recruit ~4,000 HBV patients and ~16,000 chronic HCV patients.

The CDC Foundation and industry partners are funding CheCS and the pilot feasibility project is nearly complete. The CDC Foundation is making efforts at this time to finalize commitments from major partners. CheCS will be launched for five years beginning in the fall of 2009 with a preliminary budget of $1.5-2 million per year.

To "act globally to disseminate effective interventions," CDC is continuing its 15-year partnership with WHO to promote implementation of HBV vaccination around the world. At this time, 370 million persons have chronic HBV worldwide, but prevalence greatly varies by region with the highest prevalence in Asia. DVH plays a major role in achieving WHO/WPRO goals to (1) decrease the prevalence of chronic HBV infection to <2% in every country in the Western Pacific Region by 2012 with eventual reduction of <1% prevalence; (2) improve delivery of timely birth dose of HBV vaccination to 80% coverage; and (3) ensure timely administration of the birth dose of HBV vaccination within 24 hours of birth. CDC is a member of the certification process that was established to monitor achievement of these goals.

CDC procured partnerships with the ZeShan Foundation and other groups to implement global HBV initiatives. CDC, WHO and the ZeShan Foundation made a commitment to promote the adoption of comprehensive policies in China and Asia that aim to assist in the eventual elimination of HBV. The ZeShan Foundation donated a gift to DVH of ~$660,000 gift to support global HBV elimination goals established for the Western Pacific Region. DVH will use this gift

to establish a position in WHO's China office to provide technical expertise and conduct other viral hepatitis prevention activities.

In addition to conducting activities in support of its four strategic imperatives for viral hepatitis prevention, DVH also has been engaged in a strategic planning process. DVH solicited assistance from federal and community partners to respond to a review IOM is currently conducting on CDC's domestic viral hepatitis prevention projects. The rationale for the IOM review is outlined below.

Chronic HBV and HCV are responsible for morbidity in 4.5 million persons and 15,000 deaths each year in the United States, but these diseases are under-recognized as public health problems. Although viral hepatitis prevention is complex, interventions can prevent infection and slow or halt disease. Public health capacity for viral hepatitis is inadequate at this time and guidance is needed to prioritize current and future resources in this area. IOM convened an expert panel to provide advice on the proper investment in chronic viral hepatitis prevention and identify prevention priorities for this investment.

The IOM expert panel will provide guidance in four key areas: (1) developing strategies for preventing HBV and HCV infections; (2) creating approaches for reducing morbidity and mortality from chronic HBV and HCV infections; (3) assessing the type and quality of data needed from state and local viral heaptitis surveillance systems to guide and evaluate prevention services; and (4) addressing the needs of Asian Americans, AAs and foreign-born populations. The multidisciplinary IOM panel launched the review in December 2008 with two public meetings and will convene closed meetings through August 2009. IOM will complete its report in November 2009 and release the final document in early 2010.

Several CHAC members were concerned that CDC established a strong partnership and financial relationship with China in the global HBV elimination effort. The members noted that Africa and other regions of the world have similarly high prevalence rates of HBV, but CDC has not formed collaborations in these areas.

CHAC noted that CDC's partnerships with industry in conducting viral hepatitis prevention activities are a departure from its traditional collaborations. On the one hand, the CHAC members pointed out that CDC's relationships with industry could be financially beneficial in the current environment of severe budgetary constraints. On the other hand, the CHAC members emphasized that these partnerships could be perceived as a conflict of interest because funding from industry could influence CDC's viral hepatitis prevention research or other activities.

Dr. Ward made several follow-up remarks to CHAC's questions and comments. CDC and WHO recently conducted a site visit to Africa to develop a process for establishing regional goals, a technical plan and an operations plan for viral hepatitis. The federal agency will allocate resources to convene a technical expert panel in September-October 2009 that will be charged with administering serologic surveys and collecting data on HBV in six pilot regions in Africa.

DVH acknowledges that its risk-based approach to HCV screening poses challenges to testing and linking at-risk persons to care. However, DVH will place strong emphasis on resolving this issue over the next two years. For example, DVH has been exploring the possibility of replicating the HIV model in which screening policies are expanded from a risk-based approach. DVH also is examining strategies to accelerate licensure of rapid HCV tests to improve detection of cases of recent HCV infection in various settings and align rapid point-of-care testing with ongoing HIV testing.

DVH is directing its attention to HCV due to recent reports from multiple European cities of HCV transmission from sexual contact among HIV-positive MSM. DVH is currently collaborating with partners in the United States to collect and publish surveillance and laboratory data to determine whether similar epidemiological patterns are occurring outside of Europe. Based on the outcomes of these efforts, DVH will collaborate with HIV partners to develop and disseminate appropriate HIV/HCV interventions and revise existing HCV screening guidelines

DVH's partnerships with industry on global HBV elimination is based on clearly defined roles, a transparent process and input from a diverse group of stakeholders. Resources from these collaborations are playing a critical role in helping DVH to accomplish its mission and expand its viral hepatitis activities.

Dr. Fenton added that DVH's collaboration with industry was a deliberate strategy to broaden CDC's longstanding role in public-private partnerships. DVH is serving as an innovative model for CDC in leveraging new and creative funding sources to strengthen its viral hepatitis programs. NCHHSTP is planning future exciting roundtable discussions with pharmaceutical companies to explore other strategies to expand public-private partnerships and further advance activities related to prevention, training, capacity development and the health workforce.

## Update on Surveillance Activities

**Dr. James Heffelfinger**, of DHAP, explained that the purposes of surveillance data are to determine the incidence and prevalence of disease, monitor trends, inform the allocation of resources, and develop and evaluate public health interventions. CDC routinely improves the quality and usefulness of surveillance data by periodically revising methods to collect, manage and disseminate information.

The objective of national HIV surveillance is to monitor and characterize the epidemic, including its determinants and epidemiological dynamics, such as prevalance, incidence and antiretroviral resistance to guide public health actions at federal, state and local levels. CDC collects HIV surveillance data on the entire spectrum of disease, including infection, diagnosis, CD4 count, viral load, drug resistance, progression to AIDS and death. All 58 project areas will deploy the electronic HIV/AIDS Reporting System (eHARS) by the end of 2009.

CDC developed a national plan as a standardized approach to assess the performance of the HIV surveillance system annually using process and outcome standards. The national plan also includes processes to provide performance feedback to surveillance areas; use evaluation findings to improve the quality, usefulness and efficiency of data and surveillance systems; and implement the "Program for Detecting Inaccurate or Fraudulent Counting" as called for by the Ryan White HIV/AIDS Program.

A number of efforts are underway at CDC to advance the collection, management and dissemination of HIV surveillance data in the future. Data streams for HIV incidence, resistance and enhanced perinatal surveillance will be integrated in eHARS. Specimen collection for resistance testing will be phased out of the Variant, Atypical and Resistant HIV Surveillance Program. The collection of viral genetic sequence information from routine medical care will be implemented. Laboratory reporting of CD4 and viral load data will be improved as a critical indicator in determining the stage of disease and entry into care.

Reporting laws and practices in all 58 project areas were reviewed and showed that 32 areas collect information on all CD4 values and 41 areas collect data on any viral load result. HIV data will be enhanced through the development of procedures and policies for geocoding and SDH. The term "HIV/AIDS" will be replaced with "diagnosis of HIV infection" in annual HIV/AIDS surveillance reports. All data will be displayed by year of diagnosis rather than by year of report. The surveillance reports will include HIV/AIDS rates, tables for the United States alone and the United States plus dependent areas, HIV/AIIDS by race/ethnicity, and the number and prevalence of HIV/AIDS by state and metropolitan statistical area.

The HIV/AIDS surveillance reports will use the new multiple imputation technique to account for missing data and a new methodology to adjust for reporting delays. Discussions are being held with state and local areas to assess the use of a new "presumed heterosexual category." HRSA and CDC are collaborating to develop supplemental surveillance reports to present HIV/AIDS data used for Ryan White funding. CDC is reviewing and updating the 2004 guidelines for epidemiologic profiles.

DHAP uses two systems to conduct behavioral surveillance. The National HIV Behavioral Surveillance System (NHBS) helps direct and evaluate national and local HIV prevention efforts by identifying patterns of HIV risk behavior and measuring exposure to and use of prevention services. NHBS is implemented in rounds of three annual rotating cycles for MSM, IDUs and heterosexuals at risk for HIV infection.

Formative research conducted at the start of each cycle and different sampling methods are used for each population. A venue-based and time-space sampling method is used for MSM. A respondent-driven sampling method is used for IDUs. Both types of sampling methods were used for the pilot cycle for at-risk heterosexuals. HIV testing is offered to eligible recruits who accept the interview. The target sample size is 10,500 eligible participants per cycle. The most recent cycle of NHBS included 21 cities with high AIDS prevalence.

The Supplemental Behavioral Assessment Project (SBAP) increases understanding of the knowledge, attitudes and practices related to HIV infection among MSM, minority MSM and other persons at risk for infection who may not be interviewed by NHBS. SBAP also increases knowledge of HIV serostatus among persons at risk for HIV infection. The SBAP methods include rapid behavioral assessments at events attracting persons who might be at risk for HIV, interviewer-administered surveys using handheld computers, combined systematic and convenience sampling, and rapid HIV testing at selected events.

DHAP performed a spatial analysis to identify neighborhoods where at-risk heterosexuals live. Data from the NHBS/at-risk heterosexual pilot project were evaluated to determine whether statistically significant geographic clusters of HIV infection among at-risk heterosexuals exist in cities that implement NHBS; identify poverty and other social factors associated with these clusters; determine whether geography could be used to identify at-risk heterosexuals; and inform methods for future cycles of NHBS/at-risk heterosexual projects. The Space-Time Scan Statistics Program was used to identify likely clusters of high concentrations of NHBS/at-risk heterosexuals who had HIV-positive test results and plot these clusters on maps.

The Medical Monitoring Project used three-stage probability sampling. Stage 1 was state-level sampling in which all states had a chance of being selected. The likelihood of selection was proportional to the number of reported AIDS cases as of December 2002. Stage 2 was provider-level sampling in which every facility providing HIV care in the sampled state had a chance of being selected with probability. The likelihood of selection was proportional to the number of PLWH in care at each facility. In each state, ~25-50 facilities were sampled. Stage 3 was patient-level sampling in which every HIV-infected person $\geq$18 years of age receiving care in a sampled facility had a positive probability of being selected. In each project area, ~400 patients were sampled.

Overall, changes CDC has made in collection, management and dissemination methods will improve the quality, usefulness and impact of HIV surveillance data. Spatial analyses of NHBS data will help target testing and prevention interventions to heterosexuals at risk for HIV infection. Spatial analyses also might be used to target heterosexuals at risk for other infections and other groups that are difficult to locate. Three-stage sampling will help CDC to obtain a representative sample of HIV-infected persons in care for surveillance and clinical outcomes. This method also could be used to obtain representative samples of persons with other conditions.

**Dr. Hillard Weinstock** is the Team Lead of DSTDP's Surveillance and Special Studies and Chair of the NCHHSTP Surveillance Workgroup. He explained that the goal of PCSI is to provide holistic, science-based, comprehensive and high-quality prevention services to appropriate populations at every interaction with the healthcare system. The vision of PCSI is to remove barriers to and facilitate the adoption of service delivery integration at the client level by aligning NCHHSTP activities, systems and policies with the goal. Integrated surveillance provides a data-driven foundation for program integration and aims to remove barriers to and facilitate the adoption of surveillance integration at the client level.

NCHHSTP held an external consultation on PCSI in August 2007 to engage its internal and external stakeholders, develop a center-wide vision and objectives for PCSI, and plan and prioritize PCSI activities. The participants identified several surveillance and strategic information gaps during the consultation: lack of data to describe the intersection among HIV, TB, STDs and viral hepatitis; lack of data to assess the prevalence and distribution of integrated preventive services; and lack of data to monitor and evaluate performance on integration.

The participants identified a number of surveillance barriers or facilitators that might support or hinder PCSI: policies related to categorical funding, confidentiality and reporting forms; incompatibility among data systems; the absence of cross-communication; little political will to reduce duplication; lack of an epidemiologic infrastructure for viral hepatitis, TB, and STD; a weak information technology infrastructure; reluctance of HIV programs to share data with TB or STD programs; and the need for additional funding.

NCHHSTP has taken several actions to address recommendations the participants made on surveillance and data collection to support PCSI. The participants advised NCHHSTP to reduce redundancy with standardized data elements and improved system compatibility. DSTDP and DHAP developed a combined STD/HIV interview record in which data collected for these systems only need to be entered once.

The participants advised NCHHSTP to conduct demonstration projects for integrated electronic surveillance and data management. CDC recently expanded the STD Surveillance Network (SSuN) to integrate surveillance systems and processes at both clinic and population levels, monitor program activities, and broaden the scope to include HIV, hepatitis and other service areas. The robust SSuN platform is a flexible and timely system with strong data management and analytic capacity that provides access to high-quality and informative data at local and national levels. The database can be queried as well. SSuN's coverage area from 2009-2013 includes 12 project areas.

The participants advised NCHHSTP to mandate data sharing and matching by developing security and confidentiality standards across programs. The NCHHSTP Surveillance Workgroup is currently drafting center-wide guidelines in an effort to share and match data and focus on co-morbidities. The workgroup also is convening staff throughout NCHHSTP to improve surveillance communications across state and federal programs. The workgroup produced the *2006 NCHHSTP Disease Profile* and will soon release the 2007 report. NCHHSTP will continue to address the remaining two recommendations of focusing on co-morbidities and providing funding, support and training for PCSI.

CHAC applauded NCHHSTP on its ongoing efforts to integrate surveillance activities and data systems for HIV, TB, STD and viral hepatitis. The members made a number of comments for CDC to consider in its ongoing efforts to improve surveillance.

- CDC should identify specific data elements that are important to capture in HIT standards for surveillance and quality of care related to public health.

- CDC should include integrated surveillance data in the annual HIV/AIDS annual report and make these data available in an electronic rather than a printed format.
- CDC should develop a systematic approach to provide clinicians with surveillance data within a 12-month time period to impact targeted prevention and policy efforts. The timeliness of surveillance data must be improved to allow providers to detect changes or trends in the epidemiology of disease within clinical and community settings. CDC should give consideration to establishing an integrated "HIV, STD TB and Hepatitis Surveillance Division" to address problems related to the timeliness of surveillance data.
- CDC should collect information on STD trends from project areas because these data are used to drive implementation of NAAT for gonorrhea and chlamydia.
- CDC should allocate additional funding to states for surveillance. Severe budget cuts to state health departments limit both the quality and quantity of data that states can report to CDC.

The panel of NCHHSTP presenters made several remarks in response to CHAC's specific questions and comments. CDC established a major standard to report 85% of expected cases within 12 months of the diagnosis year. CDC hopes to capture and measure this standard in eHARS beginning in 2010. CDC also intends to implement its first evaluation measures for surveillance in January 2010.

CDC implements several methods to disseminate surveillance data to local programs to inform decision-making, policies and practices at the local level. SBAP is designed to administer surveys and perform HIV rapid testing at special events; analyze data collected at these events, and develop and disseminate a summary of findings to project areas within three months. Quarterly reports are produced and provided to project areas to guide programmatic decision-making. Efforts are made to summarize *MMWR* surveillance reports and provide these data to local areas within one year.

## Update by the Ryan White Reauthorization Workgroup

Dr. Sweet conveyed that the Federal AIDS Policy Partnership (FAPP) developed the "HIV/AIDS Community Consensus on the Future of the Ryan White HIV/AIDS Treatment Modernization Act" position paper. As of April 27, 2009, 165 organizations had endorsed FAPP's proposed recommendation to extend reauthorization of the Ryan White legislation for at least three years.

Dr. Sweet announced that the CHAC Ryan White Reauthorization Workgroup convened four conference calls and extensively discussed the proposed recommendations in the FAPP document. The recommendations focused on authorization levels; continued protection for states with maturing HIV case data; extension of TGA eligibility; extension of hold harmless provisions; provision of food pursuant to a doctor's prescription as a core medical service; and revised definition of medical transportation as a core medical service. The FAPP document also proposed technical fixes for four issues: ADAP rebate dollars, unobligated funds, Ryan White

Part D medical expense reporting requirements, and severity of need index and client level data.

Dr. Sweet asked the members to provide input on the most appropriate action CHAC should take in response to the FAPP document, but she noted that some of the proposed language had minority viewpoints. She also pointed out that Mr. Harold Phillips, a member of both CHAC and the Reauthorization Workgroup, was unable to attend the meeting. He sent a letter asking CHAC to write a letter independent of the FAPP document in support of healthcare reform, the continuation of the Ryan White legislation, and the extension or removal of the current sunset date of September 30, 2009 for the Ryan White Program. Dr. Sweet pointed out that both the FAPP document and Mr. Phillips' letter were distributed to CHAC for review.

In response to Dr. Sweet's request for CHAC to take action, a motion was properly placed on the floor and seconded by Rev. Hickman and Dr. Agins, respectively. CHAC would write a letter to Dr. Wakefield highlighting the following key points. CHAC supports the extension of the Ryan White Care Act for three years. Continuation of Ryan White is critically important for needy persons who would be adversely impacted if the extension is not granted. The extension should not be delayed because healthcare reform is expected. Increased funding is necessary for all parts of the Ryan White Program.

The letter to Dr. Wakefield also would emphasize the tremendous progress HRSA has made in its treatment and care activities, particularly the implementation of the Ryan White Program by HAB, increased emphasis on workforce issues, and new resources to CHCs to increase their capacity to provide clinical care to HIV and STD patients. **CHAC unanimously approved the motion.**

Dr. Sweet would draft the letter to Dr. Wakefield and distribute the document to CHAC for review and submission of comments by a specific deadline.

## CHAC Business Session

Dr. Hook entertained a motion for CHAC to approve the previous meeting minutes. A motion was properly placed on the floor and seconded by Drs. Rawls and Agins, respectively, for CHAC to adopt the previous meeting minutes. CHAC **unanimously approved** the "Draft November 17-18, 2008 Meeting Minutes" with no changes or discussion.

Ms. Antigone Hodgins and Dr. Bruce Agins proposed a concept for CHAC to convene a new "HIV Care and Treatment in the New Millennia" Workgroup. The workgroup would be charged with assessing and researching current medical care systems for PLWH/AIDS through the Ryan White Program, CHCs and other avenues. The workgroup also would examine trends to integrate HIV primary medical care and investigate the medical home, chronic care model and other models for application to the HIV care system.

Ms. Hodgins and Dr. Agins would draft a schedule of monthly workgroup meetings within the next two weeks. The workgroup most likely would be convened for 12-18 months and would regularly report its progress during CHAC meetings. The workgroup's recommendations would be based on evidence and best practices that support other models. A draft description of the proposed workgroup and its activities was distributed to CHAC for review.

Dr. Fenton commended Ms. Hodgins and Dr. Agins for committing their time and leadership to assure the productivity of the workgroup. He strongly supported the formation of the workgroup as a mechanism for CDC and HRSA to obtain guidance on integrating prevention into treatment and care. However, he asked the workgroup to focus on the broader aspects of sexual health, such as treatment and care for chronic hepatitis, acute STDs, and prevention of STDs in PLWH.

A motion was properly placed on the floor by Dr. Cunningham, seconded by Dr. Rawls, and **unanimously approved by CHAC** to convene the new workgroup. The membership would include Ms. Hodgins and Dr. Agins as co-chairs; Mr. Hopkins and Drs. Cunningham, Del Rio, Hook, Mayer, Rawls and Sweet as members; and CDC and HRSA staff for technical support and resources.

A motion was properly placed on the floor and seconded by Drs. Rawls and Agins, respectively. CHAC would write a letter to Dr. Frieden highlighting the following key points. CHAC is concerned about the consequences of level or diminished funding for STD/HIV prevention activities because populations that need these services are increasing due to economic stressors throughout the nation. While continuing STD control activities in the public health sector, STD screening and education should be promoted and emphasis should be placed on safety net services for STD care and sexual health among providers and the healthcare system.

The letter to Dr. Frieden also would emphasize the tremendous progress CDC has made in its prevention activities. CHAC commends CDC on its efforts to integrate programs and views PCSI as an exciting model. CHAC look forwards to additional presentations in the future on integration and collaborations within NCHHSTP. CHAC advises CDC to place more emphasis on integrated surveillance of HIV and STD.

CHAC asks CDC to administer a survey to determine the impact of the economic crisis on HIV and other STDs. CHAC supports integration at the agency level in which CDC's data on screening, surveillance and other prevention activities would be harmonized with HRSA's data on treatment and care. CHAC strongly supports CDC's broader focus on sexual health, health promotion and health protection. **CHAC unanimously approved the motion.**

Drs. Rawls and Hook would draft the letter to Dr. Frieden and distribute the document to CHAC for review and comments.

CHAC **generally agreed** on four action items:

- CHAC would extend invitations to Drs. Wakefield and Frieden to attend the next meeting to serve on a "New Leadership Panel."

- CHAC would write a letter to the HHS Secretary, with copies to Drs. Frieden and Wakefield, requesting the allocation of ARRA dollars for HIT to support public health integration functions.
- CHAC would use its letter to the HHS Secretary as an opportunity to extend an invitation to CMS to attend future meetings.
- CHAC would write a thank-you letter to Mr. Crowley for attending the May 2009 CHAC meeting. The letter also would serve as an invitation for Mr. Crowley to attend the next CHAC meeting.

Dr. Sweet informed the members that the CHAC charter was distributed in the meeting packets. She encouraged the new members to read the charter to gain a better understanding of the coordination, collaboration and communication between CDC and HRSA to improve the lives of patients and strengthen capacity to deliver health care. The charter also emphasizes the importance of CHAC's role and activities in providing valuable guidance and recommendations on HIV/STD prevention and treatment.

Drs. Sweet and Hook led CHAC in a review of future agenda items that were raised over the course of the meeting. The members proposed placing presentations, overviews or updates of the following topics on future agendas:

- Remarks by the "New Leadership Panel" of Mr. Crowley and Drs. Frieden and Wakefield.
- Presentation by the Substance Abuse and Mental Health Service Administration (SAMHSA) on the inclusion of mental health care in HIV/STD prevention and care.
- Update by Dr. Parham Hopson on extension of the Ryan White Program for three years.
- Presentation of data by HRSA on 75%/25% core medical services.
- Update by HRSA on client-level data collected by Ryan White grantees.
- Progress report by CHAC's new HIV Care and Treatment Workgroup.
- Presentation by the National Association of Community Health Centers and National Institute of Mental Health (NIMH) on integrating prevention into care, particulary at CHCs and prevention activities for PLWH.
- Presentation on packaging prevention activities, such as treatment for prevention.
- Interagency presentation by CDC, HRSA and VA on troops returning from war with HIV.
- Presentation by SAMHSA and NIMH on the broader and cross-cutting concept of sexual health and its impact and the need for providers to perform sexual health assessments.
- Discussion on the role of surveillance in informing CDC and HRSA.
- Discussion with Congressional staffers regarding their perspectives on the future of public health.
- Presentation by HRSA on HCV care for co-infected patients.
- Presentation by CDC on herpes simplex and human papillomavirus.
- Presentation by HHS on strategies that will be implemented for each HHS agency to incorporate emerging priorities of the Administration, such as CER, health reform, electronic medical records and other health information technologies to assist providers in assuring complete medical visits for their patients.

- Update on PEPFAR, including emerging priorities established by the new Global AIDS Coordinator.
- Presentation by HHS on strategies to shift the focus from the prevention, treatment and care of chronic diseases to a perspective of infectious disease with chronic conditions.
- Presentation by CHCs on their efforts to expand HIV/AIDS services with new ARRA funding.
- Presentation on HIV testing and treatment, including high HIV seroincidence rates in Washington, DC and other communities that rival undeveloped countries.
- Summary by HRSA on the Workforce Summit that will be held in August 2008.
- Update by CDC on Pre-Exposure Prophylaxis for HIV Prevention studies.
- Presentation by NIH on its prevention initiatives.
- Update by Dr. Parham Hopson on HHS's CER projects.

Dr. Hook led a session for each CHAC member to propose a recommendation to enhance HIV/ STD prevention and treatment activities conducted by CDC and HRSA. The outcomes of this discussion are outlined below.

- CDC should continue to pursue PCSI projects to strengthen integration and cooperation among programs in the future.
- CDC and HRSA should continue to promote the maintenance and expansion of a skilled and capable workforce for HIV/STD prevention and treatment.
- CDC should not place any population on the "back burner," particularly Latinos due to the high incidence of HIV and STDs in this population.
- CDC should continue to focus on surveillance activities and place strong emphasis on "integrated surveillance" across divisions. These initiatives should be well defined with discernable metrics for the outcomes and use of surveillance.
- CDC should pair the 14 organizations selected for the ACT Against AIDS Campaign with existing CBOs and redistribute the $45 million to avoid failure of the initiative.
- CDC should develop health education messages and interventions to analyze combined outcomes for the same populations.
- HRSA should allocate funding to ETCs to train and build existing capacity of CHCs in improving the delivery of HIV/STD treatment and care.
- HRSA should strengthen the relationship between HAB and BHPr.

## Public Comment Session

**Ms. Laura Hanen** is the Director of Government Relations for the National Alliance of State and Territorial AIDS Directors (NASTAD). NASTAD applauds CHAC for supporting the extension of the Ryan White Program, but the letter to Dr. Wakefield should ask for proactive changes in the law in addition to CHAC's request to repeal the sunset date.

NASTAD requests CHAC's assistance in encouraging HRSA to take urgent action on the Ryan White extension in a thoughtful legislative process. NASTAD and other professional societies are advocating for prevention and wellness in healthcare reform legislation to support the crumbling public health infrastructure and address workforce issues. NASTAD and other HIV/AIDS organizations need outcome-based and cost-effectiveness data from CDC and HRSA to make a strong case for additional funding.

Ms. Hanen asked CHAC to consider holding the public comment session on the first day of CHAC meetings in the future. This approach would provide an opportunity for CHAC to consider feedback from the public during its business session.

**Mr. Ronald Johnson** is the Deputy Executive of AIDS Action Council (AAC). AAC commends CHAC's support of a three-year extension of the Ryan White Program. As of May 20, 2009, 213 organizations representing 41 states and territories endorsed the FAPP consensus document with an unprecedented level of community support. AAC appreciates CHAC's awareness of the critical need to continue the Ryan White Program even after healthcare reform legislation is passed.

AAC thanks CHAC for its attention to important workforce issues, including workforce shortages in HIV care, the need for strong workforce development, the role of AETCs in the creation of a skilled HIV health workforce, and the role of nurses in the delivery of HIV care. AAC requests CHAC's new HIV Care and Treatment Workgroup to discuss the critical role of nurses in HIV care. AAC will submit recommendations to CHAC on training and workforce development at a future meeting.

**Dr. Peter Leone**, of the National Coalition of STD Directors (NCSD), emphasized that severe economic and workforce stresses are occurring at state and local levels. NCSD strongly supports program integration to improve the efficiency of delivering HIV and other STD services. The disease intervention specialist (DIS) workforce will bear the largest responsibility for achieving the goals of PCSI and integrated partner-related services. However, the DIS workforce should be defined more broadly than STDs and given resources to match this expanded role. For example, the DIS workforce at the state level could be broadened to bridge HIV testing, case management and care.

DHAP should play a leadership role in expanding the role of the DIS workforce by allocating direct funding to state and local agencies through cooperative agreements or indirect funding to client referral services. Resources should be targeted to STD programs, states with integrated programs and other groups with solid experience in this area.

CHAC should emphasize the critical role of public health in healthcare reform. Most notably, the local workforce is primarily responsible for surveillance of HIV and STD cases. STD programs should be a strong partner and have common goals with other infectious disease programs. NCSD will present compelling data to CHAC at a future meeting to assist in making a strong case on the need to expand the role of the DIS workforce.

**Ms. Debra Fraser-Howze** is the Vice President of Governmental and External Affairs for OraSure Technologies and founder of the National Black Leadership Commission on AIDS. CHAC should extensively discuss impending changes in the landscape of HIV prevention and treatment with the availability of the rapid HIV test. Most notably, the existing public health infrastructure and resources are not adequate to provide care to new cases that will be detected with the rapid HIV test.

CHAC should develop creative strategies to communicate, engage and partner with industry in its activities. For example, industry conducts research studies and collects data that are extremely important to government agencies. CHAC should strengthen its role as advocates to leverage more funding for CDC and HRSA and address concerns regarding the entire spectrum of prevention, care and treatment.

## Closing Session

CHAC applauded Ms. Margie Scott-Cseh and Ms. Shelley Gordon, CHAC's Committee Management Specialists at CDC and HRSA, respectively, for their outstanding efforts in planning and organizing the meeting and providing excellent administrative support. The next CHAC meeting is tentatively scheduled for November 2-3, 2009 in Washington, DC, but the members would be polled by e-mail to confirm this date.

With no further discussion or business brought before CHAC, Dr. Sweet adjourned the meeting at 2:25 p.m. on May 20, 2009.

I hereby certify that to the best of my knowledge, the foregoing Minutes of the proceedings are accurate and complete.

_____ _____

Date Edward W. Hook III, M.D., Co-Chair
CDC/HRSA Advisory Committee on
HIV and STD Prevention and Treatment

_____ _____

Date Donna Sweet, M.D., Co-Chair
CDC/HRSA Advisory Committee on
HIV and STD Prevention and Treatment